(1)

90-494

No.

In The

Supreme Court of the United States

October Term, 1990

BLUE CROSS AND BLUE SHIELD OF ALABAMA
and TRUCK RENTALS OF ALABAMA, INC.,

Petitioners,

vs.

FRED BROWN,

Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

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QUESTIONS PRESENTED

Three questions are presented:

1. Whether the Eleventh Circuit failed to follow *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 S.Ct. 948 (1989), when it created a standard of judicial review which affords little or no deference to a fiduciary exercising discretionary authority under the terms of the plan because the fiduciary is operating under a potential conflict of interest?

2. What is the appropriate standard of judicial review in an action challenging denial of benefits under 29 U.S.C. § 1132(a)(1)(B) where the language of the plan grants discretionary authority to make claim determinations to a fiduciary who is operating under a potential conflict of interest?

3. Whether the plan sponsor and insurer of an insured employee benefit plan under ERISA are entitled to determine contractually the insurer's discretionary authority and the appropriate standard of judicial review of an exercise of that authority within the terms of the plan?

RULE 29.1 LISTING

Petitioner, Blue Cross and Blue Shield of Alabama, has no parent company or subsidiary that is not a wholly-owned subsidiary.

Petitioner, Truck Rentals of Alabama, Inc., is controlled by its parent corporation, Baggett Transportation Company. This petitioner has no subsidiary corporation that is not a wholly-owned subsidiary.

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Petitioners, Blue Cross and Blue Shield of Alabama and Truck Rentals of Alabama, Inc., respectfully pray that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Eleventh Circuit, entered in the above-entitled proceeding on April 25, 1990.

OPINIONS BELOW

The opinion of the Court of Appeals for the Eleventh Circuit is reported at 898 F.2d 1556, and is reprinted in the Appendix hereto, p. A-1, *infra*.

The Memorandum Opinion of the United States District Court for the Northern District of Alabama (Pointer, J.) granting summary judgment in favor of petitioners has not been reported. It is reprinted in the Appendix hereto, p. A-39, *infra*.

JURISDICTION

Respondent commenced this action in the Circuit Court of Jefferson County, Alabama (the Tenth Judicial Circuit of the State of Alabama) asserting various common law claims against petitioners for an alleged failure to pay benefits under an employee welfare benefit plan. On September 23, 1988, petitioners removed this action to the United States District Court for the Northern District of Alabama, Southern Division, pursuant to the district court's federal question jurisdiction, 28 U.S.C. § 1331, and the civil enforcement provisions of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1132(a). On February 2, 1989, the district court entered summary judgment in favor of petitioners.

Respondent appealed to the Eleventh Circuit Court of Appeals under 28 U.S.C. § 1291 on February 27, 1989.

On April 25, 1990, the Eleventh Circuit Court of Appeals entered a judgment and opinion reversing the

district court and remanding the case for further proceedings.

Petitioners timely filed a petition for rehearing and suggestion of rehearing *en banc*, which was denied by order of the court dated June 19, 1990. Appendix, p. A-43, *infra*.

The jurisdiction of this Court to review the judgment and opinion of the Eleventh Circuit Court of Appeals is timely invoked under 28 U.S.C. § 1254(1).

STATUTES INVOLVED

Section 502(a)(1) of ERISA, 29 U.S.C. § 1132(a)(1), provides as follows:

> A civil action may be brought –
>
> (1) by a participant or beneficiary –
>
> (A) for the relief provided for in subsection (c) of this section, or
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan . . .

Section 502(e)(1), 29 U.S.C. § 1132(e)(1), provides as follows:

> Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this title brought by the Secretary or by a participant, beneficiary, or fiduciary.

State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under subsection (a)(1)(B) of this section.

STATEMENT OF THE CASE

Respondent, Fred Brown, was a participant in an employee welfare benefit plan maintained by his employer, Truck Rentals of Alabama, Inc. ("Truck Rentals"), through Baggett Transportation Company.[1] (R. 1-17-4). This plan is maintained for the purpose of providing to the employees of Truck Rentals medical, surgical, and hospital care benefits through the purchase of insurance from petitioner, Blue Cross and Blue Shield of Alabama ("Blue Cross"). Blue Cross is a non-profit, nonstock health care service plan organized under and governed by §§ 10-4-100 through 10-4-115 of the Code of Alabama (1975). Blue Cross served as Claims Administrator of the employee benefit plan of Truck Rentals. (R. 1-17-4).

In September of 1987, respondent was hospitalized at St. Charles General Hospital in New Orleans, Louisiana, on two separate occasions. (R. 1-17-4, 45). At the

[1] Truck Rentals of Alabama, Inc. is a subsidiary corporation partially owned and controlled by Baggett Transportation Company. Baggett Transportation Company entered into the Group Hospital and Major Medical Contract with Blue Cross and Blue Shield of Alabama on behalf of Truck Rentals.

time of the first admission, respondent was complaining of worsening headaches, chest tightness, and shortness of breath. Respondent also had an abnormal EKG and discharge from his sinuses. This hospitalization was for the evaluation of both potential cardiac disease and the discharge from respondent's sinuses. Medical examination during the course of this hospitalization indicated that respondent had no significant cardiac disease, but did have an inflammation of the sinus which would eventually require surgery.[2] Respondent received medical treatment for his complaints and was discharged in a medically stable condition.

Respondent's second admission was the following week to perform the previously scheduled surgery. At the time of this second admission, the medical records indicate that respondent was suffering from no acute distress; his vital signs and temperature were normal; and the nurses notes from the day of admission indicate that respondent was admitted with no complaints. Surgery was performed, and respondent was subsequently discharged.

As Claims Administrator, Blue Cross is charged with the task of processing claims for determination of whether and in what amount benefits should be paid under the terms of the Plan. (Plan Section XIV(G)). In this

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[2] Specifically, the discharge summary from Brown's first hospitalization contains the following notation dated September 25, 1987: "Surgery is being scheduled for next week. The patient will be discharged now and readmitted next week for the surgery." (R. 1-20-68).

regard, the Plan provides that Blue Cross' reasonable determinations shall be final and conclusive.

> As a condition precedent to coverage, it is agreed that whenever the Company [Blue Cross] makes reasonable determinations which are not arbitrary or capricious in the administration of the Contract (including, without limitation, determinations whether services, care, treatment, or supplies are Medically Necessary, whether surgery is Cosmetic Surgery, or whether charges are reasonable), such determinations shall be final and conclusive.

(Plan, Section IX(K)).

Additionally, the Plan requires preadmission certification for all inpatient hospital admissions except for emergency or maternity admissions. (R. 1-17-4, 64). In this regard, the Plan provides as follows:

> *Preadmission Review and Certification of Inpatient Hospital Services Benefits*
>
> To be eligible for Inpatient Hospital Service Benefits, all Inpatient Hospital Admissions and stays except for Medical Emergency or Maternity Care must be reviewed, approved, and certified by the Company [Blue Cross] as being Medically Necessary before the Member is admitted to the hospital.

(Plan, Section V.A.5). The term "Medical Emergency" is defined in the Plan as follows:

> "Medical Emergency" means a sudden and unexpected onset of a medical condition the symptoms of which are acute and of such severity as to require, in the Company's [Blue Cross'] judgment, immediate medical attention . . .

(R. 1-17-51). The Plan excludes all benefits for hospital admissions which should have been precertified but were not. (R. 1-17-68, 72). Specifically, the Plan states that no benefits shall be provided, whether or not the admission is recommended or prescribed by a physician with respect to the following:

> Services or expenses furnished to a Member for or during a hospital admission or stay for other than medical emergency or maternity care unless the Company [Blue Cross] has approved and precertified the admission and stay before the Member was admitted in accordance with Section V.A.5.

(Plan, Sections VI.A.33. VI.B.36).[3]

Respondent did not obtain preadmission certification for either of the hospital admissions mentioned above. (R. 1-17-4). After extensive review of the medical records of respondent's admissions, Blue Cross determined that respondent's initial admission was a medical emergency, and the failure to obtain preadmission certification was excused. (R. 1-17-46). However, no evidence was found in the medical records of a medical emergency at the time of respondent's second admission, and in an exercise of its discretionary authority, Blue Cross denied benefits because preadmission certification should have been

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[3] Review of non-emergency hospital admissions on a pre-admission basis serves two important purposes. First, such review benefits the individual claimant in that a mechanism is provided whereby the claim can be reviewed prior to costs being incurred. Second, to the extent that unnecessary hospital admissions are avoided or identical services can be rendered on a less costly outpatient basis, the cost of coverage for the participants as a whole is reduced.

obtained. *Id.* Respondent contends that this denial was improper because a state of medical emergency existed at the time of the second admission or alternatively because the second admission should be treated as an extension of the first.

Respondent filed this action in the Circuit Court of Jefferson County, Alabama on August 29, 1988. The complaint asserts various common law claims against petitioner based upon Blue Cross' denial of benefits for respondent's second hospital admission. On September 23, 1988, this action was removed to the United States District Court for the Northern District of Alabama pursuant to 28 U.S.C. § 1331 and this Court's holding in *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987).

Petitioner subsequently filed for summary judgment, and on February 2, 1989, the District Court granted summary judgment in favor of petitioners holding as follows:

> After consideration of the statement of facts submitted by each party, the court finds that material issues are not in dispute. The medical plan expressly provides for pre-admission certification unless the admission constitutes an emergency or is related to maternity care. Further, there is no dispute that plaintiff failed to acquire pre-admission certification on both hospital admissions. The court notes that there is some evidence that the second admission might be treated as a continuation of the first admission which did satisfy the emergency condition for coverage. Further, the court notes that there is some evidence that the second admission was also an emergency, hence eligible for coverage under the terms of the Plan.

> The court finds, however, that a rational basis exists for Blue Cross' decision not to extend coverage to the second admission. There is substantial evidence to support the conclusion of the health care provider that there were two separate admissions and that the second admission did not constitute an emergency admission. Therefore, Blue Cross' denial of plaintiff's claim for benefits cannot be said to be arbitrary and capricious. *See Griffis v. Delta Family-Care Disability*, 723 F.2d 822 (11th Cir. 1984) (to disturb decision of the committee administering employee benefits plan, plaintiff must establish that decision was arbitrary or capricious). Accordingly, defendant's motion for summary judgment is due to be granted.

Appendix p. A-41-42, *infra*. On February 27, 1989, respondent appealed this judgment to the United States Court of Appeals for the Eleventh Circuit.

During the time this appeal was pending, this Court's opinion in *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 109 S.Ct. 948 (1989), was decided.

In reversing the opinion of the District Court, the Eleventh Circuit pronounced a new standard of review in cases for benefits under § 1132(a)(1)(B) of ERISA which imposes essentially *de novo* review with little or no deference to the decision of a plan fiduciary or administrator given discretionary authority under the terms of the plan if the fiduciary or administrator is operating under a potential conflict of interest. Specifically, the Eleventh Circuit held as follows:

> In accordance with the foregoing common law principles, we hold that when a plan beneficiary demonstrates a substantial conflict of interest on the part of the fiduciary responsible for benefits

> determinations, the burden shifts to the fiduciary to prove that its interpretation of plan provisions committed to its discretion was not tainted by self-interest. That is, a wrong but apparently reasonable interpretation is arbitrary and capricious if it advances the conflicting interest of the fiduciary at the expense of the affected beneficiary or beneficiaries unless the fiduciary justifies the interpretation on the ground of its benefit to the class of all participants and beneficiaries.

Brown, 898 F.2d at 1566-67, appendix, p. A-24-25, *infra*. (Footnote omitted).

REASONS FOR GRANTING THE WRIT

I. The Eleventh Circuit's Decision is Directly Contrary to this Court's Decision in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 S.Ct. 948 (1989).

The Eleventh Circuit's holding in the present case is directly contrary to the applicable principles for determining the appropriate standard of review as stated by this Court in *Firestone*. Notwithstanding the plan's grant of discretionary authority to Blue Cross to "make reasonable determinations which are not arbitrary or capricious" in the administration of the plan, the Eleventh Circuit imposed upon the parties a heightened standard of review that is in essence a *de novo* review which affords little or no deference to the claims determinations of Blue Cross as fiduciary of the plan. This heightened standard of review is made applicable to any employee benefit plan in which the decisionmaking fiduciary is potentially subject to a conflict of interest regardless of whether the parties have agreed to a narrower standard of review in

the plan itself. Moreover, this standard of review, in practice, distinguishes between insured and self-insured plans resulting in increased administrative expense for those employers without the financial means to accept the risk of self-insurance in their employees' health and medical benefits.

Because the Eleventh Circuit based its holding upon its interpretation and application of this Court's opinion in *Firestone*[4], an examination of this decision is merited. In *Firestone*, respondents were six former employees of Firestone Tire & Rubber Company ("Firestone") who worked in Firestone's Plastics Division when it was sold as a going concerning to Occidental Petroleum Company ("Occidental") in late 1980. Each of respondents were rehired by Occidental in their same positions without interruption and at the same rate of pay. At the time of the sale, Firestone maintained a termination pay plan which was governed by ERISA. This plan was unfunded, and Firestone served as both administrator and fiduciary of the plan. Respondents' claims for termination pay under the plan were denied. According to Firestone's interpretation of the plan as administrator, the sale of its Plastics Division did not constitute a "reduction in work force" such that respondents were eligible to receive severance benefits. Upon denial of their claims,

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[4] "Although *Firestone* does not alter in form the standard applied to review of the fiduciary's decision, the substance of review was subtly altered by the opinion. We examine herein the impact of this change. Our application of the *Firestone* opinion gives the conclusion that the decision of the District Court must be reversed and remanded." *Brown*, 898 F.2d at 1558, appendix, p. A-3-4, *infra*.

respondents filed suit pursuant to 29 U.S.C. § 1132(a) for severance benefits under the termination pay plan. The District Court granted summary judgment in Firestone's favor holding that Firestone's decision not to pay severance benefits to respondents was neither arbitrary nor capricious.

On appeal, the United States Court of Appeals for the Third Circuit held that where an employer is itself the fiduciary administrator of an unfunded benefit plan, its decision to deny benefits should be subject to *de novo* judicial review because of the lack of impartiality of the employer. In so holding, the Third Circuit recognized that "the propriety of the standard [of review] depends on the context in which it is used." *Bruch v. Firestone Tire & Rubber Co.*, 828 F.2d 134, 140 (3rd Cir. 1987). This Court granted certiorari to resolve the conflicts among the Court of Appeals as to the appropriate standard of review in actions under 29 U.S.C. § 1132(a)(1)(B). *Firestone Tire & Rubber Co. v. Bruch*, 109 S.Ct. 948, 953 (1989).

In *Firestone*, this Court held that the appropriate standard of judicial review in an action for benefits under ERISA depends upon the language of the Plan. A *de novo* standard of review in a § 1132(a)(1)(B) action challenging denial of benefits under an ERISA plan is appropriate unless the plan language grants discretionary authority to the administrator or fiduciary whose determination is being challenged. Where the benefit plan gives the administrator or fiduciary discretionary authority to interpret the terms of the plan, a deferential standard of review is appropriate. In allowing the terms of the plan to control, this Court rejected the rationale of the Third

Circuit which employed a *de novo* review to counteract any partiality on the part of the decisionmaker.

A. The Eleventh Circuit Standard Affords Too Little Deference to the Decision of a Fiduciary.

The new standard of review created by the Eleventh Circuit in the present case affords no deference to a claims' determination by an insurer of an ERISA plan subject to a potential conflict of interest, except to the limited extent the insurer can prove that denial of the claim benefits plan beneficiaries exclusively. This standard makes a single factor in the standard of review calculus – potential conflict of interest – determinative of the issue and represents a significant departure from the deferential standard which this Court's opinion in *Firestone* indicates is appropriate.

> Consistent with established principles of trust law, we hold that a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or construe the terms of the plan. Because we do not rest our decision on the concern for impartiality that guided the Court of Appeals, *See* 828 F.2d at 143-46, we need not distinguish between types of plans or focus on the motivation of plan administrators and fiduciaries. Thus, for purposes of actions under § 1132(a)(1)(B), the *de novo* standard of review applies regardless of whether the plan at issue is funded or unfunded and regardless of whether the administrator or fiduciary is operating under a possible or actual conflict of interest. Of course, if a benefit plan gives discretion to an administrator or fiduciary

> who is operating under a conflict of interest, that conflict must be weighed as a "factor[] in determining whether there is an abuse of discretion."

Firestone, 109 S.Ct. at 956. The Eleventh Circuit's opinion, in effect, reembodies the Third Circuit's approach in *Firestone*, disregarding this Court's repudiation of that approach on review.

As noted in *Firestone*, "[t]rust principles make a *deferential* standard of review appropriate when a trustee exercises discretionary powers." *Firestone*, 109 S.Ct. at 954. (Emphasis added.) Despite adhering to the arbitrary and capricious nomenclature, the Eleventh Circuit imposes the functional equivalent of a *de novo* standard in reviewing the fiduciary's decision. This heightened standard of review involves a two-step process. After first subjecting the fiduciary's interpretation of a disputed plan provision to *de novo* review, the reviewing court is to defer to an interpretation with which it disagrees only if "the fiduciary justifies the interpretation on the ground of its benefit to the class of all participants and beneficiaries." *Brown*, 898 F.2d at 1567, appendix, p. A-25, *infra*. Because in the normal case it will be impossible to show whether denial of a particular claim benefits all participants and beneficiaries of the plan, this standard affords only illusory deference to the claims determinations made by the fiduciary, notwithstanding the plan's grant of discretionary authority to the fiduciary to make such determinations. This holding contravenes the most fundamental principles of trust law as well as the teachings of *Firestone* and should not be allowed to stand.

B. The Eleventh Circuit Standard Takes No Account of the Standard of Review Agreed Upon by the Parties in the Plan.

Firestone unequivocally states "neither general principles of trust law nor a concern for impartial decisionmaking, however, forecloses parties from agreeing upon a narrower standard of review." *Firestone*, 109 S.Ct. at 956. Even if the Eleventh Circuit's opinion is allowed to stand as an embellishment upon the standard of review applicable to a trustee exercising discretionary authority, *Firestone* clearly states that the concern for impartial decisionmaking which motivated the Eleventh Circuit in this case does not foreclose parties from contractually agreeing upon a narrower standard of review.[5] As previously noted, the plan at issue in this case provides that whenever Blue Cross "makes reasonable determinations which are not arbitrary or capricious in the administration of the Contract" such determinations shall be final and conclusive. Under the standard of review agreed upon by the parties in this case, a rational basis for Blue Cross' good faith determination that respondent's claim should be denied is all that is required.[6] The Eleventh

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[5] This holding is in keeping with trust principles. "By the terms of the trust a discretionary power may be conferred on the trustee to determine questions relating to the distribution of trust property. There is no public policy which prevents the avoidance of litigation by committing the determination with finality to the trustee." Restatement (Second) of Trusts § 187, Comment k (1959).

[6] *See Griffis v. Delta Family-Care Disability*, 723 F.2d 822, 825 (11th Cir. 1984), where notwithstanding a potential conflict of

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Circuit completely ignored Firestone's mandate allowing the parties the freedom to contractually determine an appropriate standard of review in keeping with the degree of discretion granted the fiduciary in the plan.

C. The Eleventh Circuit Standard Impermissibly Distinguishes Between Plans Based Upon Method of Funding.

Finally, the Eleventh Circuit opinion acknowledges that application of this new standard of review will create a distinction between insured and self-insured plans.

> The burden of demonstrating the reasons for a challenged plan interpretation will, by and large, draw a distinction between plans that are truly trusts and plans that are based solely on contracts or policies for insurance. Decisions on behalf of a plan in the form of a trust lend themselves less readily to the accusation of conflicting interests and are more easily justified.

Brown, 898 F.2d at 1567, appendix, p. A-27, *infra*. Adoption of such a standard is directly contrary to *Firestone*'s teaching that actions under § 1132(a)(1)(B) should be judged under the same standard of review "regardless of whether the plan at issue is funded or unfunded and

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interest on the part of the employer administrator it was held the "judicial role is limited to determining whether the [committee's] interpretation was made rationally and in good faith – not whether it was right." Under the arbitrary and capricious standard as previously applied by the Eleventh Circuit, the conflicted administrator's decision "need not be the best possible decision, only one with a rational justification." *Id.*; *see also Gehrhardt v. General Motors Corp.*, 581 F.2d 7, 12 (2nd Cir. 1978).

regardless of whether the administrator or fiduciary is operating under a possible or actual conflict of interest."[7]

The distinction developed between insured and uninsured plans by application of this new standard of review is poignantly demonstrated by a comparison of the Eleventh Circuit's holding in *Jett v. Blue Cross & Blue Shield of Alabama*, 890 F.2d 1137 (11th Cir. 1989). The benefit plan at issue in *Jett* contained a grant of discretionary authority identical to that given Blue Cross in the present case. Moreover, the issue over which Blue Cross exercised its discretion in *Jett* – the medical necessity of a portion of the claimant's hospital stay – involved an analysis and review of medical records substantially similar to the review conducted by Blue Cross to determine whether Mr. Brown's second admission was a medical emergency. However, in *Jett*, the Eleventh Circuit appropriately held that the function of judicial review was limited to a determination of "whether there was a reasonable basis for the decision, based upon the facts as known to the administrator [Blue Cross] at the time the decision was made." *Jett*, 890 F.2d at 1139. If a reasonable basis exists, the decision is entitled to deference by the reviewing court.

The only difference between the benefit plan in *Jett* and the present plan is that the plan's sponsor in *Jett*,

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[7] This Court's opinion in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), demonstrates a strong reluctance to diminish the uniform application of ERISA by distinguishing between insured and self-insured plans and recognized such a distinction only where Congress has explicitly authorized it by statute.

South Central Bell Telephone Company, is large enough and has the financial means to maintain its employee benefit plan on a self-insured basis. It is ironic that the Eleventh Circuit has created a legal environment whereby the most wealthy employers are free to implement cost-saving measures such as preadmission certification with a limited amount of judicial intervention while small employers are stripped of their ability to implement such measures notwithstanding identically worded plans. The exercise of some discretion is essential to the success of these measures. Yet, the Eleventh Circuit has taken it upon itself to rewrite the terms of insured benefit plans to eliminate the discretion afforded fiduciaries of these plans to administer programs designed to curb health care costs. By injecting a multi-layered judicial review into every disputed benefit claim under an insured plan, the Eleventh Circuit has not only multiplied the administrative expense a small employer incurs in maintaining a health insurance plan, but it has also infringed upon the parties' basic freedom to contract placing the federal judiciary above both the state insurance regulators and the marketplace as a control over potentially conflicting interests.

The Eleventh Circuit attempts to justify this distinction based upon what it identified as an "inherent conflict between the fiduciary role and the profit-making objective of an insurance company." *Brown*, 898 F.2d at 1562, appendix, p. A-14, *infra*. This led the Court to conclude that "one reason for limiting the deference when the fiduciary suffers a conflict of interest is to discourage arrangements where a conflict arises." *Brown*, 898 F.2d at 1565, appendix, p. A-21, *infra*. However, this notion is

ill-conceived. Of those employees and dependents of employees who receive health and medical insurance through employer-sponsored insurance programs, approximately 62%, or 91,000,000 individuals, receive health and medical insurance through fully insured benefit plans.[8] Often, these plans are maintained by small employers who have neither the financial means nor expertise to maintain and administer a self-insured program. To the extent that the Eleventh Circuit's holding deprives fiduciaries of these plans of the ability to administer the plan consistently without judicial intervention, the administrative expense of maintaining fully insured plans will undoubtedly rise and be passed to those who can afford it least. The wisdom of discouraging arrangements whereby so many individuals obtain health and medical insurance is questionable at best.

II. The Standard of Review Established by the Eleventh Circuit for Reviewing Claims Determinations Made Pursuant to Discretionary Authority Granted Within the Terms of the Plan is Contrary to Established Principles of Trust Law.

Firestone teaches that trust law forms the basis for determining the appropriate standard of review for actions under § 1132(a)(1)(B). Under established principles of trust law, it is necessary to first look to the terms of the trust to determine the extent of a trustee's powers.[9]

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[8] See, Health Insurer's Association of America, 1988 Employer Survey.

[9] Applying this principle in a post-*Firestone* case under § 1132(a)(1)(B), the Seventh Circuit noted as follows:

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"A trustee has such powers as are specifically conferred by the terms of the trust and such powers as are necessary or appropriate for carrying out the purposes of the trust and are not forbidden by the terms of the trust." 3 W. Fratcher, Scott on Trusts § 186, p. 6 (4th ed. 1988) (hereinafter "Scott on Trusts"). The benefit plan in the present case confers discretionary authority upon Blue Cross to make "reasonable determinations which are not arbitrary or capricious in the administration of the Contract". All such determinations "shall be final and conclusive."

Prior to ERISA's enactment and application, courts were guided by general principles of the common law of trusts in resolving pension disputes. In *Hoffa v. Fitzsimmons*, 673 F.2d 1345 (D.C. Cir. 1982), the Court of Appeals for the District Court of Columbia had occasion to comment at length regarding the validity of a clause in a pension plan which rendered the trustee's determination final.

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> At the heart of [*Firestone*] is an admonition to the courts that they refer to the common law of trusts for guidance in ERISA decisions. Under the common law, courts will not review the discretionary decisions of trustees and other fiduciaries *de novo*, but will look only for the trustee's abuse of its discretionary authority. Restatement (2d) of Trusts § 187 (1959). What constitutes an abuse of discretion, however, depends in the first instance on how the trustee's discretion is defined [in the trust agreement].

Exbom v. Central States, Southeast and Southwest Areas Health and Welfare Fund, 900 F.2d 1138, 1142 (6th Cir. 1990).

> It is well settled that provisions in the trust instrument that render the trustee's determination of a beneficiaries entitlement conclusive are enforceable, subject to certain limitations grounded principally in the *terra firma* of good faith. As the draftsmen of the Second Restatement noted: "There is no public policy which prevents the avoidance of litigation by committing the determination with finality to the trustee." Restatement (Second) of Trust § 187, comment (k) (1959); see generally III Scott on Trusts § 187 at 1502-07 (3rd ed. 1967). . . .
>
> Almost needless to say, a finality clause does not confer on a trustee *carte blanche* to make any payment that he chooses, be he prompted by whim, caprice, altruism, or malice. . . . Still, it is manifest from even a cursory perusal of the treatises and relevant cases that a properly drafted finality clause or comparable provision vesting exclusive power with regard to entitlement or eligibility determinations in the trustee does serve to limit judicial review of rulings made under that clause or power.

Hoffa, 673 F.2d at 1354-55.

This Court's opinion in *Firestone* clearly states that a deferential standard of review is appropriate where the language of the benefit plan confers discretionary authority upon a fiduciary to make claims determinations.

> Trust principles make a deferential standard of review appropriate when a trustee exercises discretionary powers. See Restatement (Second) of Trusts § 187 (1959) ("[w]here discretion is conferred upon the trustee with respect to the exercise of a power, its exercise is not subject to control by the court except to prevent an abuse by the trustee of his discretion"). See also G. Bogert & G. Bogert, Law of Trusts and Trustees

> § 560, pp. 193-208 (Rev. 2d ed. 1980). A trustee may be given power to construe disputed or doubtful terms, and in such circumstances the trustee's interpretation will not be disturbed if reasonable. Bogert & Bogert § 559, at 169-171. Whether "the exercise of a power is permissive or mandatory depends upon the terms of the trust." 3 W. Fratcher, Scott on Trusts § 187, p. 14 (4th ed. 1988). Hence over a century ago we remarked that "[w]hen trustees are in existence, and capable of acting, a court of equity will not interfere to control them in the exercise of a *discretion vested in them by the instrument* under which they act." *Nichols v. Eaton*, 91 U.S. 716, 724-725, 23 L.Ed. 254 (1875) (emphasis added). See also *Central States, Southeast & Southwest Areas Pension Fund v. Central Transport, Inc.*, 472 U.S., at 568 ("The trustees' determination that the trust documents authorize their access to records here in dispute has significant weight, for the trust agreement explicitly provides that 'Any construction [of the agreement's provisions] adopted by the trustees in good faith shall be binding upon the Union, Employees, and Employers.' ").

Firestone, 109 S.Ct. at 954.

Application of a deferential standard of review in circumstances where the language of the plan grants discretionary authority for claims determinations to a fiduciary or trustee is in keeping with the principles of trust law applied to pension and welfare benefit plans prior to ERISA. Under pre-ERISA standards, a determination by a trustee involving an exercise of discretionary authority granted to the trustee in the plan was "not [to] be disturbed absent a showing that the actions of the trustee were arbitrary, capricious or in bad faith." *Bono v. Kramer*, 191 N.E.2d 760, 764 (Mass. 1963). Similarly, in

Marsh v. Greyhounds Lines, Inc., 488 F.2d 278, 280 (5th Cir. 1974), the predecessor court of the Eleventh Circuit held that where a plan provided that "all decisions of the trustees in administering the Plan shall be final", there must be some showing of bad faith before the decision of the trustee could be reversed. *See also, Judge v. Kortenhaus*, 192 A.2d 320, 328 (N.J. Super. 1963) (must show unreasonable or arbitrary abuse of discretion); *Kloman v. Doctors Hospital*, 76 A.2d 782, 785 (D.C. 1950) (must be a showing that trustees "have acted out of fraud, malice, bad faith, or in an arbitrary abuse of their discretionary powers"). Pre-ERISA pension cases recognize that where trustees make good faith determinations pursuant to their discretionary powers, a court should not substitute its judgment in place of the trustee's decision. *See, Edmonds v. White*, 118 A.2d 608, 610 (Del. 1955) ("It is not a question as to what the Court would have decided in the absence of this grant of discretionary power to the executors").

The Eleventh Circuit correctly notes that this Court's holding in *Firestone* identifies conflict of interest as "a factor[] in determining whether there is an abuse of discretion." *Firestone*, 109 S.Ct. at 956. However, the Eleventh Circuit's analysis in the present case looks to this "factor" to the exclusion of all others and makes this element determinative of the appropriate standard of review of a claim for benefits under § 1132(a)(1)(B). Such a result is uncalled for under *Firestone*, out of step with principles of trust law applicable to ERISA cases, and a clear violation of the terms of the plan.

Under the Restatement (Second) of Trusts, § 187, the following factors "may be relevant" in determining

whether a trustee has abused the discretionary authority granted it under the terms of the trust:

> (1) the extent of the discretion conferred upon the trustee by the terms of the trust; (2) the purposes of the trust; (3) the nature of the power; (4) the existence or nonexistence, the definiteness or indefiniteness, of an external standard by which the reasonableness of the trustee's conduct can be judged; (5) the motives of the trustee in exercising or refraining from exercising the power; (6) the existence or nonexistence of an interest in the trustee conflicting with that of the beneficiaries.

Restatement (Second) of Trusts, § 187, comment d (1959). The Restatement elaborates upon these factors noting that a court will not interfere with a trustee's exercise of discretionary authority "unless the trustee in exercising or failing to exercise the power acts dishonestly, or with an improper even though not a dishonest motive, or fails to use his judgment, or acts beyond the bounds of a reasonable judgment." *Id.*, comment e. "The mere fact that if the discretion had been conferred upon the court, the court would have exercised the power differently, is not a sufficient reason for interfering with the exercise of the power by the trustee." *Id.*

Under the Eleventh Circuit's analysis, the threat to the duty of loyalty posed by a potential conflict of interest is given such weight that it is determinative of the appropriate standard of review regardless of the terms of the plan. This is exactly backward from well-established principles of trust law which dictate that the terms of the trust control. "By the terms of the trust, the trustee may

be permitted to do what in the absence of such a provision in the trust instrument would be a violation of his duty of loyalty." Scott on Trusts, § 170.9.[10] In allowing establishment of employee welfare benefit plans through the purchase of insurance, 29 U.S.C. § 1002(1), Congress presumably recognized that conflicts of interest may arise.[11] It is commonplace for ERISA to, in some instances, defer to the terms of the benefit plan.[12] The

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[10] As the Sixth Circuit noted in *Estate of Fruehauf v. Commissioner of Internal Revenue*, 427 F.2d 80, 86 (6th Cir. 1970),

> It is a well established rule of law that a fiduciary cannot use his position to benefit himself in his individual capacity . . . There is, however, an equally well established countervailing rule of law that a fiduciary may be authorized by the terms of the instrument creating his powers to do that which in the absence of such provision would be a violation of his fiduciary duty of loyalty.

Id.

[11] It is noteworthy that the common law of trusts recognizes that in some circumstances a fiduciary may operate under an unavoidable conflict of interest. "A fiduciary may without any fault on his part be in a position where his own interests conflict with those of his principal, in which case he is not necessarily bound to sacrifice his own interests entirely, although he is not entitled to give them a preferential treatment." Scott on Trusts, § 504.

[12] *See e.g.* § 405(c) of ERISA, 29 U.S.C. § 1105(c), which allows the plan instrument to provide for procedures allocating fiduciary responsibilities among named fiduciaries; § 402(a)(1) of ERISA, 29 U.S.C. § 1102(a)(1), which allows the plan to select one or more individuals to be named fiduciaries; § 202(a) of ERISA, 29 U.S.C. § 1052(a), which allows the plan to select which of the statutorily allowed minimum participation standards it will employ; § 203 of ERISA, 29 U.S.C. § 1053, which

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Eleventh Circuit's approach to determining the standard of review which completely neglects the terms of the plan, the purposes of the plan, the nature of the trustee's power, and the existence of an external standard by which the reasonableness of the trustee's conduct can be judged is contrary to established principles of trust law, and for this reason should be reversed.

III. Fiduciaries, Administrators, and Reviewing Courts Require Guidance from this Court With Respect to the Appropriate Standard of Review For Actions Under 29 U.S.C. § 1132 Where the Plan Grants a Fiduciary Discretionary Authority to Make Claims Determinations.

During the 18-month period since *Firestone* was decided, a great deal of confusion has developed among the circuits regarding the appropriate standard of review of a claim determination made by a fiduciary exercising discretionary authority granted to it under the terms of the plan. Approximately 147,000,000 Americans receive health and medical insurance through employer-sponsored programs[13], and the large majority of these programs are ERISA-governed employee benefit plans. Since *Firestone*, the number of these plans granting a fiduciary

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allows the plan to designate, within certain options, how quickly an employee's interest will vest; § 206(a) of ERISA, 29 U.S.C. § 1056(a), which allows the plan to determine whether distribution before named retirement age will be allowed; and § 203(b) of ERISA, 29 U.S.C. § 1053(b), which allows the plan to determine whether to disregard years of service before age 18.

[13] See Bureau of Census Current Population Survey (1987).

or administrator discretionary authority to construe the plan in regards to benefit determinations is, predictably, on the rise. Consequently, the appropriate standard of judicial review is a matter of great significance to administrators, fiduciaries, and reviewing courts in their determination of ERISA claims.

Although most courts recognize that *Firestone* requires some degree of deference to be afforded a fiduciary's decision under these circumstances, preliminary indications are that the circuits are unsure of the appropriate standard of review to be applied. In *Lakey v. Remington*, 874 F.2d 541, 544 (8th Cir. 1989), the Eighth Circuit held that where a fiduciary has discretionary authority to construe the terms of the plan, the benefit determination is to be reviewed under the arbitrary and capricious standard. However, the Fourth Circuit held that *Firestone* "mandated total abandonment of the 'arbitrary and capricious' formulation" in favor of review under the abuse of discretion standard for reasonableness. *DeNobel v. Vitro Corp.*, 885 F.2d 1180, 1186-87 (4th Cir. 1989).[14] The Seventh Circuit has applied an abuse of discretion standard that varies from reasonableness to the most deferential standard of arbitrary and capricious depending on how the trustee's discretion is defined in the plan. *Exbom v. Central States Health and Welfare Fund*, 900 F.2d 1138, 1142 (7th Cir. 1990). Finally, the Eleventh

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[14] The Fourth Circuit subsequently stated that the abuse of discretion standard is "perhaps broader and less deferential than the arbitrary and capricious standard." *Richards v. United Mine Workers Health and Retirement Fund*, 895 F.2d 133, 135-36 (4th Cir. 1990).

Circuit's approach allows review under the arbitrary and capricious standard (which it equates with abuse of discretion) unless the fiduciary's exercise of discretion is subject to a potential conflict of interest entitling the decision to little or no deference. *Brown*, 898 F.2d at 1558, n.1., appendix, p. A-3, *infra*; *Cf. Jett*, 890 F.2d at 1137.

Because of the confusion created among the various circuits, further guidance is needed in regards to the standard of review created by the Eleventh Circuit in the present case because it places too high and too vague a burden on a fiduciary in the exercise of its discretion under an insured plan. A reviewing court is allowed to defer to the judgment of the administrator only in the limited circumstance in which it can be demonstrated that the fiduciary's decision operates exclusively in the interest of the plan participants and beneficiaries. The opinion suggests that this burden can be carried if "the facts . . . bear out an insurance company's assertion that its interpretation of its policy is calculated to maximize the benefits available to plan participants and beneficiaries at a cost that the plan sponsor can afford (or will pay)." *Brown*, 898 F.2d at 1568, appendix, p. A-27, *infra*. The degree of specificity with which this must be shown is not made clear and, if too literally applied, will not admit to available proof. In the normal case it would be impossible to prove that a different outcome in a single participant's benefit claim would drive the cost above what a plan sponsor can afford or will pay.

In the absence of a reversal by this court, administrators and fiduciaries of employee benefit plans will face a continued uncertainty as to the finality of their decisions

in the administration of these plans, their ability to contractually provide for discretionary authority and review of an administrator's decision, and the extent to which courts may interpose their judgments in place of the administrator or fiduciary. This unnecessarily complicates administration of the plan. The Eleventh Circuit's opinion in this case does not follow those principles established by this court in *Firestone* and should not be allowed to stand.

CONCLUSION

For these reasons, a writ of certiorari should issue to review the decision of the Court of Appeals.

Respectfully submitted,

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September 17, 1990

Fred BROWN, Plaintiff-Appellant,

v.

BLUE CROSS AND BLUE SHIELD OF ALABAMA, INC., et al., Defendants-Appellees.

No. 89-7151.

United States Court of Appeals,
Eleventh Circuit.

April 25, 1990.

Leo E. Costello, Costello & Stott, Birmingham, Ala., for plaintiff-appellant.

Lawrence B. Clark, Lange, Simpson, Robinson & Somerville, Sally S. Reilly, Timothy A. Palmer, Charles C. Pinckney, Birmingham, Ala., for defendants-appellees.

Appeal from the United States District Court for the Northern District of Alabama.

Before JOHNSON, Circuit Judge, RONEY*, Senior Circuit Judge, and MELTON **, District Judge.

MELTON, District Judge:

Fred Brown ("Brown") was denied hospitalization benefits under a group health plan because he had not obtained a precertification of the hospital admission. The district court held that the decision to deny benefits under this ERISA plan was not arbitrary and capricious and entered summary judgment for defendants. Brown

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* *See* Rule 34-2(b), Rules of the U.S. Court of Appeals for the Eleventh Circuit.

** Honorable Howell W. Melton, U.S. District Judge for the Middle District of Florida, sitting by designation.

argues on appeal that there were material issues of fact and that the district court failed to apply the governing law. We reverse and remand for further proceedings.

Brown, an employee of Truck Rentals of Alabama Inc., was a participant in Truck Rentals' group health care plan established pursuant to the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 *et seq.* Blue Cross and Blue Shield of Alabama, Inc. ("Blue Cross"), provides insurance coverage under the plan for a monthly premium.

The plan automatically covers the cost of in-patient hospital care arising from a medical emergency but provides coverage in other cases only when Blue Cross has "approved and precertified the admission and stay" before the participant's admission to the hospital. Brown was in the hospital twice for the same condition. The first visit was covered as a medical emergency; the second was not.

Brown was admitted to St. Charles General Hospital in New Orleans, Louisiana, because of a sinus condition. The first hospitalization lasted from September 21 through September 26, 1987. The second began on September 29 and ended on October 6, 1987. During the second stay, Brown underwent surgery for his sinus condition. The trial court found that no preadmission certification was obtained for either period of hospitalization. Without a preadmission certification, coverage for hospital expenses depends upon whether a hospitalization was compelled by a "medical emergency."

When claims were filed for plan benefits, Blue Cross initially denied all coverage. The company later extended

coverage to the first hospitalization as a medical emergency, but refused coverage for the second. Brown filed suit to compel payment for the second period of hospitalization. He urged two theories favoring coverage, one in which the second period is treated as a continuation of the first and another in which the second period is treated as an independent emergency situation.

The district court reviewed the denial of benefits under an arbitrary and capricious standard, consistent with the law in this Circuit at the time of the decision. *See, e.g., Hoover v. Blue Cross & Blue Shield of Ala.*, 855 F.2d 1538, 1541 (11th Cir.1988); *Griffis v. Delta Family-Care Disability & Survivorship Plan*, 723 F.2d 822, 825 (11th Cir.) (adopting district court opinion), *cert. denied*, 467 U.S. 1242, 104 S.Ct. 3514, 82 L.Ed.2d 823 (1984). Brown asserts that the Supreme Court's recent decision of *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. ___, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989), decided after this case was before the district court, requires a de novo standard of review, That case, to the contrary, demonstrates that an arbitrary and capricious standard continues to be applicable here.[1]

Although *Firestone* does not alter in form the standard applied to review of the fiduciary's decision, the substance of review was subtly altered by the opinion.

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[1] *Firestone* refers to the standard of review in discretionary situations as abuse of discretion. 109 S.Ct. at 956. We have equated the arbitrary and capricious standard and the abuse of discretion standard in our post-*Firestone* cases. *See, e.g., Jett v. Blue Cross & Blue Shield of Ala.*, 890 F.2d 1137, 1139 (11th Cir.1989); *Guy v. Southeastern Iron Workers' Welfare Fund*, 877 F.2d 37, 38-39 (11th Cir.1989). We continue to use the terminology interchangeably.

We examine herein the impact of this change. Our application of the *Firestone* opinion yields the conclusion that the decision of the district court must be reversed and remanded.

SCOPE OF REVIEW

Our review of the district court's grant of summary judgment begins with a brief statement of its scope. Judge Johnson has identified an ambiguity in our prior statements of the scope of review in ERISA benefit denial review cases. *See Jett v. Blue Cross & Blue Shield of Ala.*, 890 F.2d 1137, 1140-41 (11th Cir.1989) (Johnson, J., concurring and dissenting). The issue arises from the statement in *Guy v. Southeastern Iron Workers' Welfare Fund*, 877 F.2d 37 (11th Cir.1989), that "[i]n assessing Guy's contention that the Fund improperly denied him benefits, therefore, we must determine whether the district court's finding that the Fund's decision was arbitrary and capricious is clearly erroneous." *Id.* at 39. Read literally, this statement apparently conflicts with our precedents that have uniformly treated the conclusion that an action is arbitrary and capricious as a matter of law subject to de novo review. *See, e.g., Harris v. Pullman Standard, Inc.*, 809 F.2d 1495, 1499 (11th Cir.1987); *Anderson v. Ciba-Geigy Corp.*, 759 F.2d 1518, 1522 (11th Cir.), *cert. denied*, 474 U.S. 995, 106 S.Ct. 410, 88 L.Ed.2d 360 (1985); *McKnight v. Southern Life & Health Ins. Co.*, 758 F.2d 1566, 1569 (11th Cir.1985); *Helms v. Monsanto Co.*, 728 F.2d 1416 (11th Cir.1984). But *Guy* should not be read so literally. The discussion following the statement of the scope of review considers the district court's factual findings under the clearly erroneous standard but visits relevant legal principles anew.

See Guy, 877 F.2d at 39-40. The actual exercise of de novo review over the legal conclusion belies any misconception otherwise suggested by the opinion.

This appeal from grant of summary judgment is subject to plenary review. *See, e.g., Barfield v. Brierton*, 883 F.2d 923, 933 (11th Cir.1989). We therefore apply the same legal standards that bound the district court. *Id.* The standard governing the grant of summary judgment is well-known and well expressed elsewhere, *see id.* at 933-34, so it will not be repeated here.

In our review of the substantive issue whether Blue Cross was arbitrary and capricious in its denial of Brown's claim for benefits, we "determine whether there was a reasonable basis for the decision [to deny benefits], based on the facts as known to the [fiduciary] at the time the decision was made." *Jett*, 890 F.2d at 1139. The concept of "reasonable basis," however, must be modified consistent with the following discussion of the application of the arbitrary and capricious standard in the present context.

STANDARD OF REVIEW FOR FIDUCIARY DECISIONS

In *Firestone*, the Court established de novo judicial review of an ERISA benefits denial decision "unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." 109 S.Ct. at 956. Appellant does not argue that this principle would not apply to Blue Cross in this case. The Group Hospital and Major

Medical Contract between Baggett Transportation Company and Blue Cross, which we take to be the ERISA benefit plan document[2] (hereinafter "Contract Plan"), confers discretion on Blue Cross in the matter of benefits determinations. The provision states:

> As a condition precedent to coverage, it is agreed that whenever [Blue Cross] makes reasonable determinations which are not arbitrary and capricious in the administration of the [plan] (including, without limitation, determinations whether services, care, treatment or supplies are Medically Necessary . . .), such determinations shall be final and conclusive.

Contract Plan, § IX(K). Notably, the division of ERISA duties between Baggett Transportation Company and Blue Cross provides:

> It is expressly understood and agreed by the parties to the Contract that any and all duties assigned by ERISA to the "plan administrator" shall be deemed for purposes of this Contract as duties of the Employer and not those of [Blue Cross].

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[2] All employee benefit plans must be established pursuant to a written instrument. 29 U.S.C. § 1102(a)(1) (1982). The record on appeal contains this contract and the summary booklet describing plan benefits. The booklet explains "[a]ll benefits are subject to the terms, conditions and limitations of the master contract between your group and Blue Cross and Blue Shield of Alabama." An affidavit submitted in support of Blue Cross' motion for summary judgment identifies the contract as the plan. Evidently, Baggett Transportation entered into the contract with Blue Cross on behalf of Truck Rentals.

Id., § XIII(D)(1). Thus, Blue Cross exercises its discretion as a fiduciary, not as plan administrator.[3] For our purposes, however, this distinction is not of consequence because *Firestone* applies equally to the decisions of fiduciaries and the plan administrator.

Before *Firestone*, several circuits undertook to vary the deference accorded trustee or fiduciary decisions, within the framework of the arbitrary and capricious standard, in reaction to the presence or absence of conflicting interest on the part of the decisionmaker. *See, e.g., Sage v. Automation, Inc. Pension Plan & Trust*, 845 F.2d 885, 895 (10th Cir.1988); *Van Boxel v. Journal Co. Employees' Pension Trust*, 836 F.2d 1048, 1052-53 (7th Cir.1987); *Holland v. Burlington Indus., Inc.*, 772 F.2d 1140, 1149 (4th Cir.1985), *sum. aff'd*, 477 U.S. 901, 106 S.Ct. 3267, 91 L.Ed.2d 559 (1986); *Gilbert v. Burlington Indus., Inc.*, 765 F.2d 320, 328-29 (2d Cir.1985), *sum. aff'd*, 477 U.S. 901, 106 S.Ct. 3267, 91 L.Ed.2d 558 (1986); *Jung v. FMC Corp.*, 755 F.2d 708, 711-12 (9th Cir.1985); *Dennard v. Richards Group, Inc.*, 681 F.2d 306, 314 (5th Cir.1982); *Maggard v. O'Connell*, 671 F.2d 568, 571 (D.C.Cir.1982); *see also Gesina v. General Elec. Co.*, 162 Ariz. 39, 780 P.2d 1380, 1383-85 (App.) (adopting variable deference in original opinion decided

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[3] We observe, without resolving, a contradiction between the quoted portions of the benefit plan. Blue Cross is promised finality for "reasonable determinations which are not arbitrary and capricious in the administration of the Contract. . . ." Since the contract is the benefit plan, Blue Cross is actually gaining discretion in the administration of the plan. At the same time, however, Blue Cross disavows any role as plan administrator. We leave reconciliation of this contradiction to Blue Cross.

before *Firestone* and adhering thereto in post-*Firestone* opinion on reconsideration), *rev. denied*, 162 Ariz. 39, 780 P.2d 1380 (1989). The Court's opinion in *Firestone* serves to underscore the perceptiveness of these cases.[4] In the

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[4] Both *Van Boxel* and *Jung*, it should be noted, were cited by the *Firestone* Court. *See* 109 S.Ct. at 952, 953. While it is accurate to describe *Firestone* as having "swept the standard of review board clear," *De Nobel v. Vitro Corp.*, 885 F.2d 1180, 1185 (4th Cir.1989), the effect of the opinion was in other respects unremarkable. "[T]he Court prescribed rules for judicial review of ERISA benefit denials which effectively supplanted all the lower court approaches . . . – *but without rejecting all the concepts of review embodied in those approaches.*" *Id.* (emphasis added). We have previously proceeded from this premise. *See Jett*, 890 F.2d at 1139; *Guy*, 877 F.2d at 38-39 (applying pre-*Firestone* principles concerning meaning of arbitrary and capricious standard); *cf. Boyd v. Trustees of United Mine Workers Health & Retirement Funds*, 873 F.2d 57, 60 (4th Cir.1989) ("It is obvious that to the extent it would be arbitrary and capricious under our pre-*Firestone* standard to deny benefits on such a basis, it would be an abuse of discretion to deny them under the Bruch standard."); *Lowry v. Bankers Life and Casualty Retirement Plan*, 871 F.2d 522, 525 (reserving question whether abuse of discretion standard in *Firestone* "is equivalent to or less strict than our circuit's preexisting arbitrary and capricious standard"), *denying reh'g to* 865 F.2d 692 (5th Cir.), *cert. denied*, ___ U.S. ___, 110 S.Ct. 152, 107 L.Ed.2d 111 (1989); *Batchelor v. International Bhd. of Elec. Workers Local 861 Pension & Retirement Fund*, 877 F.2d 441, 444-48 (5th Cir. 1989) (decision subsequent to *Lowry* which applies pre-*Firestone* Fifth Circuit arbitrary and capricious principles as guidance in applying *Firestone's* abuse of discretion standard). For pre-*Firestone* cases finding that the action of a fiduciary was arbitrary to capricious, see *Deak v. Masters, Mates & Pilots Pension Plan*, 821 F.2d 572 (11th Cir.1987); *Harris v. Pullman Standard Inc.*, 809 F.2d 1495 (11th Cir.1987); *McKnight v. Southern Life & Health Ins. Co.*, 758 F.2d 1566 (11th Cir.1985); *Helms v. Monsanto Co.*, 728 F.2d 1416 (11th

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same paragraph in which the Court gave its approval to plans that confer discretion on benefits decisionmakers, the Court added, "Of course, if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'factor[] in determining whether there is an abuse of discretion.' " *Firestone*, 109 S.Ct. at 956 (quoting Restatement (Second) of Trusts § 187, Comment *d* (1959)).

Our task is to develop a coherent method for integrating factors such as self-interest into the legal standard for reviewing benefits determinations. This task reaches the height of difficulty in a case such as the one before us, where an insurance company serves as the decisionmaking fiduciary for benefits that are paid out of the insurance company's assets. Several features distinguish insurance policy plans from other forms of ERISA plans.

The most familiar distinction lies in the application of certain state laws to ERISA plans. Although other forms of ERISA plans may offer the same kinds of health or other benefits that insurance policy plans offer, only insurance policy plans are subject to "any law of any

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Cir.1984). For cases finding that the action was not arbitrary and capricious, see *Hoover v. Blue Cross & Blue Shield of Ala.*, 855 F.2d 1538 (11th Cir.1988); *Chilton v. Savannah Foods & Indus., Inc.*, 814 F.2d 620 (11th Cir.1987); *Anderson v. Ciba-Geigy Corp.*, 759 F.2d 1518 (11th Cir.1985); *Griffis v. Delta Family – Care Disability*, 723 F.2d 822 (11th Cir.1984); *Fine v. Semet*, 699 F.2d 1091 (11th Cir.1983); *Paris v. Profit Sharing Plan*, 637 F.2d 357 (5th Cir. Feb.1981); *Bayles v. Central States, Southeast & Southwest Areas Pension Fund*, 602 F.2d 97 (5th Cir.1979).

State which regulates insurance." *See* 29 U.S.C. § 1144(b)(2)(A) (savings clause); *see also id.* § 1144(b)(2)(B) (so-called deemer clause, which exempts employee welfare plans from insurance regulation). Congress intended a distinction between insured and uninsured plans such that the former are subject to state regulations, for example, mandated-benefit laws, that have the effect of transferring or spreading a policyholder's risk, that are an integral part of the policy relationship between the insurer and the insured, and that are limited to entities within the insurance industry. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 738-47, 105 S.Ct. 2380, 2388-93, 85 L.Ed.2d 728 (1985) (applying mandated-benefit law to group health insurance ERISA plan); *see also Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987) (refusing to apply general contract law causes of action against group insurance policy).

Another, more important distinction derives from the trust aspect of ERISA plans. The trust nature of employee benefit plans is fundamental to ERISA. The statute provides, with enumerated exceptions, "all assets of an employee benefit plan shall be held in trust by one or more trustees." 29 U.S.C. § 1103(a). Insurance policy plans fall within the exceptions. The policy is an asset of the plan, but the insurer's assets are not thereby included in the plan. *Id.* § 1101(b)(2). Moreover, this asset of the plan, the insurance policy, is not an asset held in trust for the beneficiaries of the plan because the trust requirements of section 1103(a) do not apply "to assets of a plan which consist of insurance contracts or policies issued by an insurance company qualified to do business in a State." *Id.* § 1103(b)(1). Inasmuch as "[t]he basis for the

deferential standard of review in the first place was the trust nature of most ERISA plans," *Moon v. American Home Assurance Co.*, 888 F.2d 86, 89 (11th Cir.1989), the most important reason for deferential review is lacking.

A final distinction involves the inherent conflict between the roles assumed by an insurance company that administers claims under a policy it issued. When vested with discretion to interpret the insurance policy *qua* ERISA benefits plan, the insurance company *qua* fiduciary is measured by a standard of loyalty, *see* 29 U.S.C. § 1104(a)(1)(A), and a standard of care, *see id.* § 1104(a)(1)(B), in the exercise of its duties, *see Central States, Southeast & Southwest Areas Pension Fund v. Central Transport, Inc.*, 472 U.S. 559, 570-72, 105 S.Ct. 2833, 2840-41, 86 L.Ed.2d 447 (1985); *Local Union 2134, U.M.W. of Am. v. Powhatan Fuel, Inc.*, 828 F.2d 710, 713 (11th Cir.1987). Because an insurance company pays out to beneficiaries from its own assets rather than the assets of a trust, its fiduciary role lies in perpetual conflict with its profit-making role as a business. That is, when an insurance company serves as ERISA fiduciary to a plan composed solely of a policy or contract issued by that company, it is exercising discretion over a situation for which it incurs "direct, immediate expense as a result of benefit determinations favorable to [p]lan participants." *De Nobel v. Vitro Corp.*, 885 F.2d 1180, 1191 (4th Cir.1989) (explaining threshold for economic conflict of interest by fiduciary); *see also Slover v. Boral Henderson Clay Prod. Inc.*, 714 F.Supp. 825, 833-34 (E.D. Tex.1989); *Gesina*, 780 P.2d at 1383. We conclude, then, as has one district judge in an opinion since *Firestone*, that a "stong conflict of interest

[exists] when the fiduciary making a discretionary decision is also the insurance company responsible for paying the claims. . . . " *Jader v. Principal Mutual Life Ins. Co.*, 723 F.Supp. 1338, 1343 (D.Minn.1989).

The inherent conflict between the fiduciary role and the profit-making objective of an insurance company makes a highly deferential standard of review inappropriate. (The common-law basis for this proposition is developed *infra*.) Since the *Firestone* decision we have not considered any comparable situation. Four cases have been decided in this Circuit thus far. We briefly review each.

In *Guy v. Southeastern Iron Workers' Welfare Fund*, 877 F.2d 37 (11th Cir.1989), we affirmed the district court's conclusion that the trustees of a self-funded employee benefit plan acted in an arbitrary and capricious manner by refusing to pay a beneficiary's medical bills. We did not reach any issue related to conflicting interests because the trustees' decision did not survive the most deferential standard of review. *See id.* at 39.

In *Moon v. American Home Assurance Co.*, 888 F.2d 86 (11th Cir.1989), we applied the de novo standard of review to the denial of benefits by an insurance company on a death benefits policy. An individual, not the insurance company, was the administrator of the plan and no discretionary authority was vested in the company (thus precluding it from gaining fiduciary status). *Id.* at 88. We naturally had no occasion to examine the arbitrary and capricious standard.

Similarly, in *Baker v. Big Star Div. of the Grand Union Co.*, 893 F.2d 288 (11th Cir.1989) (as amended), we

remanded a case for application of the de novo standard to the denial of a claim for disability benefits by an insurance company that acted as claims administrator for a self-insured plan. We absolved the insurance company of either ERISA plan administrator or fiduciary status based on its purely ministerial role as an administrative servicing agent for claims processing. *Id.* at 290. Because the insurance company did not pay the benefits from its coffers and did not exercise discretion under the employee benefit plan, *Baker* does not shed light on the issues that presently concern us.

Finally, in *Jett v. Blue Cross & Blue Shield of Alabama*, 890 F.2d 1137 (11th Cir.1989,) we applied the arbitrary and capricious standard to the benefits determination made by an insurance company pursuant to a clause conferring discretionary authority in nearly the same terms as the ERISA plan in this case. The crucial difference in *Jett*, however, is the lack of any conflicting interest on the part of the insurance company. The plan was self-insured, with the insurance company acting as administrator and receiving full reimbursement from the plan sponsor for covered medical claims. *Id.* at 1138. The insurance company would no suffer any direct, immediate expense as a result of benefit determinations favorable to plan participants. Consequently, the insurance company *qua* plan administrator deserved and was accorded the highest deference in review of its claims denial decision. *Cf. Bali v. Blue Cross & Blue Shield Ass'n*, 873 F.2d 1043, 1047 n. 5 (7th Cir.1989) (no conflict of interest implicated where third party made determinations on benefits).

In summary, we face for the first time (since *Firestone*[5]) how the reconcile the inherent conflict posed by

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[5] In *Hoover, supra*, 855 F.2d at 1541, we applied the arbitrary and capricious standard to a challenge to an insurance company's interpretation of a plan provision that determined the amount of co-payment due from a plan beneficiary. This pre-*Firestone* opinion expressly acknowledges the element of the fiduciary's good faith, *id.*, but ruled against the beneficiary because he provided no record evidence to reasonably support an inference of bad faith, *see id.* at 1542-43. The inherent conflict of interest which we identify today was not implicated in *Hoover*. The beneficiary's co-payment went to the health care service provider, not the insurance company. Therefore the insurance company was not interpreting a plan provision that affected its payments or profits. Additionally, the opinion in *Hoover* does not reveal whether the insurance company paid benefits from its own funds, or from a self-insurance fund set up by the employer. We infer from excerpts from an affidavit and from the district court opinion, *see id.* at 1542, that the insurance company administered a fund established by the employer. Thus *Hoover* in on par with *Jett*.

In a district court opinion which we affirmed pursuant to 11th Cir.R. 36-1 after *Firestone* was decided, three circumstances present here entered into the district court's determination that the fiduciary was arbitrary and capricious in denying benefits. *McKinnon v. Blue Cross-Blue Shield of Ala.*, 691 F.Supp. 1314, 1319-22 (N.D. Ala. 1988), *aff'd*, 874 F.2d 820 (11th Cir.1989) (Table). First, the claims evaluator had a direct stake in the profitability of one hospital, *see id.*, at 1316, and his denial of the claim rested in part on the ability of that hospital to render services which the beneficiary sought elsewhere. The district court expressed severe reservation over this conflict of interest. *See id.* at 1318-21. Second, Blue Cross initially granted, then denied the claim. *See id.* at 1317. This reversal of position factored into the district court's evaluation of the evidence concerning the reasonableness of the respective interpretations. *See id.* at 1321. Last, the parties disputed the existence of

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benefits determinations made by an insurance company administering its own policy. While de novo review is an attractive avenue for controlling the exercise of discretion contrary to the interests of the beneficiaries, the application of this strict standard would deny Blue Cross the benefit of the bargain it made in the insurance contract.[6]

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an emergency as defined in the plan. *See id.* at 1318-19. The district court held that the concept of emergency had to conform to the unique facts of the case, which included a bungled diagnosis at one hospital and the attendant seeking of corrective care at another facility. *See id.* at 1321. While we affirmed this case without creating binding precedent, we recognize today the sound foundations for the district court's concerns.

[6] We could overcome the parties' freedom of contract by finding that a deferential standard of review is inconsistent with ERISA. The fiduciary duties section, for instance, requires adherence to the written plan documents unless their provisions conflict with statutory duties. *See* 29 U.S. § 1104(a)(1)(D); *Deak v. Masters, Mates & Pilots Pension Plan*, 821 F.2d 572, 577 n. 8 (11th Cir.1987), *cert denied*, 484 U.S. 1005, 108 S.Ct. 698, 98 L.Ed.2d 650 (1988). One conflict might be identified between the contractual provision for deferential review and the standard of loyalty itself. Another source of conflict could arise from the list of prohibited transactions between the plan and a fiduciary. 29 U.S.C § 1106(b). This list includes transactions that resemble the kinds of activities that an insurance company does in its business role that it would be barred from doing in its fiduciary role. The exceptions of section 1108(b) do not appear to apply. We observe that several states require trustees to apply to the court for instructions in some situations where exercise of their discretion faces a possible conflict of interest. *See* 3 A. Scott & W. Fratcher, *The Law of Trusts* § 187.6 (4th ed.1988); *cf. McMahon v. McDowell*, 794 F.2d 100, 110 (3d Cir.1986) (ERISA fiduciaries may have to step aside or apply to court for instruction in some conflict of interest situations), *cert. denied*, 479 U.S. 971, 107 S.Ct. 473, 93 L.Ed.2d 417 (1986).

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See Firestone, 109 S.Ct. at 954. The *Firestone* Court firmly endorsed the ability of parties to "agree[] upon a narrower standard of review." *Id.* at 956. At the same time, we must control the tension between contractual standards of review and an interpretation of ERISA that "would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted." *Id.* We therefore hold that the abuse of discretion, or arbitrary and capricious, standard applies to cases such as this one, but the application of the standard is shaped by the circumstances of the inherent conflict of interest.

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We do not find such a course compelled by *Firestone*. That opinion is ambiguous to some extent in providing guidance for the present circumstances. Strong language endorses the right of the parties to contract for a standard of review, but that right is premised on assumptions regarding trust law that do not apply to insurance policy plans. Appellees' counsel suggested at oral argument that language in the opinion applying the de novo standard of review "regardless of whether the plan at issue is funded or unfunded," *Firestone*, 109 S.Ct. at 956, indicates the Court's unwillingness to draw a distinction. This argument, however, mistakes the distinction between funded and unfunded for a very different distinction between insured and uninsured plans. While a distinction can be drawn reasonably, the *Firestone* opinion is written broadly enough, albeit dicta as applied here, to encompass review of insurance policy plans.

We are not prepared to abandon the use of the arbitrary and capricious standard for insurance policy plans that confer discretion. The duty of loyalty remains adequately preserved by finding abuse of discretion more readily when conflicting interests are apparent.

In saying that Blue Cross' benefits determinations are subject to review by the arbitrary and capricious standard, we recognize that the concept of arbitrary and capricious "must be contextually tailored." *Maggard*, 671 F.2d at 571. The degree of deference exercised in review of a fiduciary's decision ranges from slight to great, depending upon the dynamics of the decisionmaking process. *See Van Boxel*, 836 F.2d at 1052-53. In Posnerian terms, "the arbitrary and capricious standard may be a range, not a point." *Id.* at 1052; *accord Lowry v. Bankers Life & Casualty Retirement Plan*, 871 F.2d 522, 525 n. 6 (5th Cir.), *cert. denied*, ___ U.S. ___, 110 S.Ct. 152, 107 L.Ed.2d 111 (1989).

The disinterested, impartial decisionmaker deserves the greatest deference. "Where . . . the claimant does not argue or is unable to show that the trustees had a significant conflict of interest, we reverse the denial of benefits only if the denial is completely unreasonable." *Van Boxel*, 836 F.2d at 1053. *Compare De Nobel*, 885 F.2d at 1191-92 (no evidence to suggest decision was tainted by conflict of interest and explanation of denial was reasonable) *with Guy*, 877 F.2d at 39-40 (conflict of interest issue not raised by trustees acted unreasonably by denying benefits, without affording claimant notice or right of appeal, on basis of uncertain equitable right of recovery through subrogation). Correspondingly, "[w]hen the members of a tribunal – for example, the trustees of a pension fund – have a serious conflict of interest, the proper deference to give may be slight, even zero; the decision if wrong may be unreasonable." *Van Boxel*, 836 F.2d at 1052.

By describing this range we have drawn merely the outer boundaries of our inquiry. We now must fix more

precisely the method for evaluating the abuse of discretion. The *Firestone* Court has directed us to consult common law principles of trusts[7] and has facilitated the task further by mentioning a particularly illuminating source by name.

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[7] Because we have restated the standard as arbitrary and capricious, the temptation exists to consult precedent regarding the use of that standard to review administrative agency decisions. *See, e.g., Jett*, 890 F.2d at 1141-42 (Johnson, J., concurring and dissenting) (citing and quoting from *Motor Vehicle Mfrs. Ass'n v. State Farm Auto Ins. Co.*, 463 U.S. 29, 103 S.Ct. 2856, 77 L.Ed.2d 443 (1983)). In some instances an overlap is evident. *Compare, e.g., id.* (extracting duty to investigate from *Motor Vehicle Mfrs. Ass'n) with Jader*, 723 F.Supp. at 1342-43; *Slover*, 714 F.Supp. at 832-33; *Teeter v. Supplemental Pension Plan*, 705 F.Supp. 1089, 1095 (E.D. Pa.1989) (fiduciary has affirmative duty to gather information bearing on beneficiary's claim that is reasonably obtainable). We express caution, however, at wholesale importation of administrative agency concepts into the review of ERISA fiduciary decisions. Use of the administrative agency analogy may, ironically, give too much deference to ERISA fiduciaries. Decisions in the ERISA context involve the interpretation of contractual entitlements; they "are not discretionary in the sense, familiar from administrative law, of decisions that make policy under a broad grant of delegated powers." *Van Boxel*, 836 F.2d at 1050. Moreover, the individuals who occupy the position of ERISA fiduciaries are less well-insulated from outside pressures than are decisionmakers at government agencies. *See Maggard*, 671 F.2d at 571. We therefore concentrate on the common law trust principles to evaluate the application of the arbitrary and capricious standard. Of course, the common law we consider includes the cases decided under the Labor Management Relations Act. *See, e.g., Sharron v. Amalgamated Ins. Agency Servs., Inc.*, 704 F.2d 562 (11th Cir.1983) (decided under LMRA, not ERISA, but subsequently applied to ERISA situations).

Comment *d* to section 187 of the *Restatement (Second) of Trusts* lists six factors to consult to determine the question whether a trustee is guilty of abuse of discretion in exercising or failing to exercise a power.[8] These factors are:

> (1) the extent of the discretion conferred upon the trustee by the terms of the trust; (2) the purposes of the trust; (3) the nature of the power; (4) the existence or non-existence, the definiteness or indefiniteness, of an external standard by which the reasonableness of the trustee's conduct can be judged; (5) the motives of the trustee in exercising the power; (6) the existence or nonexistence of an interest in the trustee conflicting with that of the beneficiaries.

Restatement (Second) of Trusts § 187, Comment *d*.[9] The first factor is essentially considered in deciding that the

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[8] Our predecessor circuit had occasion to apply some of these principles in the breach of trust context. *See Investors Syndicate of Am., Inc. v. City of Indian Rocks Beach*, 434 F.2d 871, 878-88 (5th Cir.1970). The principles are related to the common law duty of loyalty, *see id.* at 878, which has a statutory counterpart in ERISA.

[9] A leading treatise lists nearly identical factors:

> In determining whether the trustee is acting within the bounds of a reasonable judgment the following circumstances may be relevant:
>
> (1) the extent of discretion intended to be conferred upon the trustee by the terms of the trust;
>
> (2) the existence or non-existence, the definiteness or indefiniteness, of an external standard by which the reasonableness of the trustee's conduct can be judged;

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arbitrary and capricious standard applies. The second and third factors have a constant quality dictated by ERISA. Adaptation of the remaining principles to the ERISA context is our next step.

The sixth factor is the most significant in this case. (We have set forth *supra* the analysis of the conflict of interest present in this case.) A finding of a conflicting interest has a tremendous impact on the evaluation of the fiduciary's actions.

> [T]he beneficiary need only show that the fiduciary allowed himself to be placed in a position where his personal interest *might* conflict with the interest of the beneficiary. It is unnecessary to show that the fiduciary succumbed to this temptation, that he acted in bad faith, that he gained an advantage, fair or unfair, that the beneficiary was harmed. Indeed, the law presumes that the fiduciary acted disloyally, and inquiry into such matters is foreclosed. The rule is not intended to compensate the beneficiary for any loss he may have sustained or to deprive the fiduciary of any unjust enrichment. Its sole purpose and effect is prophylactic. . . .

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(3) the circumstances surrounding the exercise of the power;

(4) the motives of the trustee in exercising or refraining from exercising the power;

(5) The existence or nonexistence of an interest in the trustee conflicting with that of the beneficiaries.

3 A. Scott & W. Fratcher, *The Law of Trusts* § 187, at 15 (4th ed.1988).

Fulton Nat'l Bank v. Tate, 363 F.2d 562, 571-72 (5th Cir.1966) (emphasis in original). In other words, one reason for limiting the deference when the fiduciary suffers a conflict of interest is to discourage arrangements where a conflict arises.[10] *Cf. Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 142-43, 105 S.Ct. 3085, 3091, 87 L.Ed.2d 96 (1985) ("the avoidance of conflicts of interest" is among the primary statutory duties imposed by ERISA on fiduciaries); *Donovan v. Bierwirth*, 680 F.2d 263, 271 (2d Cir.) (fiduciaries must "avoid placing themselves in a position where their acts [in their other roles] will prevent their functioning with the complete loyalty to participants demanded of them as [fiduciaries]"), *cert. denied*, 459 U.S. 1069, 103 S.Ct. 488, 74 L.Ed.2d 631 (1982).

The matter of conflicting interests touches on the fifth factor, improper motive, as well.

> Although ordinarily the court will not inquire into the motives of the trustee, yet if it is shown that his motives were improper or that he could not have acted from a proper motive, the court will interpose. In the determination of the question whether the trustee in the exercise of a power is acting from an improper motive the fact that the trustee has an interest conflicting with that of the beneficiary is to be considered.

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[10] ERISA has not fully incorporated the common law position on conflicting loyalties. Section 1108 creates exceptions to the list of prohibited transactions in section 1106. The purpose of those exceptions is "simply [to] make it possible to justify transactions which would otherwise be unequivocally prohibited transactions by demonstrating their fairness and reasonableness." *Marshall v. Snyder*, 572 F.2d 894, 901 (2d Cir.1978).

Restatement (Second) of Trusts § 187, Comment *g*; *accord* 3 A. Scott & W. Fratcher, *The Law of Trusts* § 187.5, at 47 (4th ed. 1988) [hereinafter *"Scott on Trusts"*]. The rationale for this approach is clear. A conflicted fiduciary may favor, consciously or unconsciously, its interests over the interests of the plan beneficiaries. *See Tate*, 363 F.2d at 571. The judicial hesitation to inquire into the fiduciary's motives will leave the beneficiaries unprotected unless the existence of a substantial conflicting interest shifts the burden to the fiduciary to demonstrate that its decision is not infected with self-interest. *See id.* at 569-79; *see also Pepper v. Litton*, 308 U.S. 295, 306, 60 S.Ct. 238, 245, 84 L.Ed. 281 (1939) (director of corporation stands in fiduciary relationship so that self-dealings with corporation must meet standard of good faith and inherent fairness from viewpoint of corporation); *Phelan v. Middle States Oil Corp.*, 220 F.2d 593, 600 (2d Cir.1955) (burden on beneficiary to prove conflict of interest, then burden shifts to trustee to show no loss to beneficiaries resulting from conflict), *cert. denied*, 349 U.S. 929, 75 S.Ct. 772, 99 L.Ed. 1260 (1955); *Gilliam v. Edwards*, 492 F.Supp. 1255, 1263-64 (D.N.J.1980) (applying *Tate* to ERISA context); *Blankenship v. Boyle*, 329 F.Supp. 1089, 1096 (D.D.C.1971) (pre-ERISA case in which *Pepper* was applied to fiduciaries of pension fund to require explanation why cash surpluses were accumulated contrary to duty to maximize trust income by prudent investment); see generally G. Bogert & G. Bogert, *The Law of Trusts & Trustees* § 543, at 40-42 (rev. 2d ed. Supp.1989).

Improper motive encompasses something different from dishonesty or bad faith. *See 3 Scott on Trusts* § 187.5, at 46-47. Even the broadest delegation of discretion to a

trustee or fiduciary is bounded by the limitation that the fiduciary cannot act from a motive other than the accomplishment of the purposes of the trust. *See, e.g., Funk v. Commissioner*, 185 F.2d 127, 130 (3d Cir.1950); *McDonald v. McDonald*, 92 Ala. 537, 9 So. 195, 196-97 (1890); *In re Estate of Smith*, 117 Cal. App.3d 511, 172 Cal.Rptr. 788 794 (1981); *Mesler v. Holly*, 318 So.2d 530, 533 (Fla. Dist.Ct.App.1975); *Lyter v. Vestal*, 355 Mo. 457, 196 S.W.2d 769, 773 (1946); *In re Alpert*, 129 A.D.2d 444, 514 N.Y.S.2d 16, 17, *appeal denied*, 70 N.Y.2d 603, 518 N.Y.S.2d 1026, 512 N.E.2d 552 (1987); *In re Bruches*, 67 A.D.2d 456, 415 N.Y.S.2d 664, 668 (1979). For example, where a trustee appears to be motivated by a desire to terminate the trust, the motive is improper and the trustee's discretionary determinations are scrutinized closely. *See Colket v. St. Louis Union Trust Co.*, 52 F.2d 390, 395-96 (8th Cir.1931), *cert. denied*, 285 U.S. 543, 52 S.Ct. 393, 76 L.Ed. 935 (1932).[11] ERISA's standard of loyalty constitutes statutory

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[11] The *Colket* opinion is interesting for its definition of an arbitrary decision. After acknowledging that determinations of the trustee are final unless the action is arbitrary, the court held:

> This limitation is merely one requiring good faith in the exercise of such power. Good faith requires an honest effort to ascertain the facts upon which its exercise must rest and an honest determination from such ascertained facts. . . . [I]f [the fiduciary] knew of matters concerning which honesty would require investigation, and failed to act, of if it knew of matters which would honestly compel a given determination and it announced to the contrary, it cannot, in law, be regarded as having exercised good faith, and its action would be arbitrary.

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recognition of the bar on improper motivation. *See Central States*, 472 U.S. at 571 n. 12, 105 S.Ct. at 2840 n. 12. We have found improper motive in ERISA cases where fiduciaries or trustees failed to act in the sole interests of the beneficiaries by acting to advance the interest of the sponsoring union, *Deak v. Masters, Mates & Pilots Pension Plan*, 821 F.2d 572, 579-81 (11th Cir.1987), *cert. denied*, 484 U.S. 1005, 108 S.Ct. 698, 98 L.Ed.2d 650 (1988), or by acting to advance their personal interests, *Iron Workers Local No. 272 v. Bowen*, 624 F.2d 1255, 1261 (5th Cir.1980).

In accordance with the foregoing common law principles, we hold that when a plan beneficiary demonstrates a substantial conflict of interest on the part of the fiduciary responsible for benefit determinations, the, burden shifts to the fiduciary to prove that its interpretation of plan provisions committed to its discretion was not tainted by self-interest. That is, a wrong but apparently reasonable interpretation[12] is arbitrary and capricious if it advances the conflicting interest of the fiduciary at the expense of the affected beneficiary or beneficiaries unless

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52 F.2d at 391. Thus, an improper motive sufficient to set aside a fiduciary's decision may be inferred from the fiduciary's failure to investigate or to interpret honestly evidence that greatly preponderates in one direction.

[12] It is fundamental that the fiduciary's interpretation first must be "wrong" from the perspective of de novo review before a reviewing court is concerned with the self-interest of the fiduciary. *See, e.g., Denton v. First Nat'l Bank of Waco*, 765 F.2d 1295, 1304 (5th Cir.1985) (first step in application of arbitrary and capricious standard is determining legally correct interpretation of disputed plan provision), *cited with approval in Jett*, 890 F.2d at 1139.

the fiduciary justifies the interpretation on the ground of its benefit to the class of all participants and beneficiaries. This, rule, we note, is an extension of the settled federal common law rule developed under the Labor Management Relations Act and subsequently applied in another context under ERISA. *See, e.g., Marshall v. Snyder*, 572 F.2d 894, 900-01 (2d Cir.1978); *Nedd v. United Mine Workers*, 556 F.2d 190, 210-11 (3d Cir.1977), *cert. denied*, 434 U.S. 1013, 98 S.Ct. 727, 54 L.Ed.2d 757 (1978); *Kaszuk v. Bakery & Confectionery Union*, 638 F.Supp. 365, 373 (N.D.Ill.1985); *Freund v. Marshall & Ilsley Bank*, 485 F.Supp. 629, 636 (W.D.Wis.1979).

We have engaged in burden shifting of this type for similar reasons in ERISA suits. In *Fine v. Semet*, 699 F.2d 1091 (11th Cir.1983), the plan committed benefits determinations to the sole discretion of the trustees. We found that "after [the beneficiary] met his initial burden of offering evidence of facially inconsistent treatment, the burden shifted to the trustees to show why they acted as they did." *Id.* at 1095. We focused on the articulated reasons given by the trustees and, given the absence of any argument or indicia of conflicting interests or improper motives[13], we noted that "[t]he reasons need not be compelling, only sufficient to take them out of the arbitrary mold." *Id.* The trustees stated they were concerned with the impact of the beneficiary's request on the financial status of the fund generally and other

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[13] The district court ruled out the existence of either prohibited self-dealing or improper motives. *See Fine v. Semet*, 514 F.Supp. 34, 43-44 (S.D.Fla.1981), *aff'd* 699 F.2d 1091 (11th Cir. 1983).

beneficiaries specifically. We accepted their rationale as a judgment on their part designed to implement the statutory "duty [imposed] on fiduciaries to act solely in the interest of plan participants and beneficiaries." *Id.*

In *Deak v. Masters, Mates & Pilots Pension Plan*, 821 F.2d 572 (11th Cir.1987), *cert. denied*, 484 U.S. 1005, 108 S.Ct. 698, 98 L.Ed.2d 650 (1988), we expressly reconciled this kind of burden shifting with the arbitrary and capricious standard in the context of improperly motivated trustees. The district court had found that the trustees of the plan amended it for the primary benefit of the sponsoring union and not for the plan beneficiaries. *Id.* at 576. On the heels of this finding, the district court rejected other apparently reasonable justifications for the plan amendment because they " '[did] not withstand the careful scrutiny with which they must be analyzed.' " *Id.* at 577 (quoting district court slip opinion). On appeal we found no inconsistency between the terminology of the district court and the traditional deference involved in the application of the arbitrary and capricious standard. *Id.* Indeed, we went further and laid the burden at the feet of conflicted fiduciaries to demonstrate their loyalty to the plan. We cautioned,

> We do not hold, however, that in all circumstances a provision similar to, or even identical with, Amendment 46 would violate ERISA. If the Trustees of a plan demonstrate that a provision is rationally related to the financial integrity of the Plan and is adopted absent from or insulated from any conflict of interest, consistent with their fiduciary duties, ERISA's protections of the participants and beneficiaries could be satisfied.

Id. at 581.

The burden of demonstrating the reasons for a challenged plan interpretation will, by and large, draw a distinction between plans that are truly trusts and plans that are based solely on contracts or policies for insurance. Decisions on behalf of a plan in the form of a trust lend themselves less readily to the accusation of conflicting interests and are more easily justified.

> That plan administrator's decisions have had a favorable impact on the balance sheet of the trust itself, however, suggests no "conflict of interest." Fiduciaries are obligated to act not only in the best interests of beneficiaries, but with due regard for the preservation of trust assets. Adverse benefits determinations may well have saved considerable sums, but that may simply reflect that the trustees, bearing in mind the interests of *all* participants and beneficiaries, 29 U.S.C. § 1104(a)(1), made a considered decision to preserve the corpus of the trust, rather than grant a doubtful claim.

De Nobel, 885 F.2d at 1191 (emphasis in original). The *Fine* case illustrates this principle. Decisions made by the issuing company on behalf of a plan based on a contract of insurance, by contrast, inherently implicate the hobgoblin of self-interest. Adverse benefits determinations save considerable sums that are returned to the fiduciary's corporate coffers. The presumption that the fiduciary is acting for the future stability of the fund cannot be entertained.

Of course, the facts may bear out an insurance company's assertion that its interpretation of its policy is calculated to maximize the benefits available to plan participants and beneficiaries at a cost that the plan sponsor can afford (or will pay). *Cf. Griffis*, 723 F.2d at 825

("Attempts to prevent unanticipated costs that may limit the resources of an employee benefits plan are among the proper concerns of a plan's administrator."). If this is a reasonable proposition, it would satisfy the fiduciary's burden to purge the taint of self-interest. The focus moves then to the familiar ways to test the fiduciary's decision against the arbitrary and capricious standard:[14] "(1) uniformity of construction; [and] (2) 'fair reading' and reasonableness of that reading. . . . " *Anderson*, 759 F.2d at 1522. The internal consistency of a plan under the fiduciary's interpretation also has relevance. *Id.* These factors should be viewed contextually, in relation to the proffered rationale for the interpretation chosen by the fiduciary. *See* Restatement (Second) of Trusts § 187, Comment *d* (fourth factor to consider in evaluating abuse of discretion is existence and definiteness of external standard by which reasonableness of fiduciary's conduct may be measured).[15]

We emphasize the central theme of our exposition: well-established common-law principles of trusts teach that a fiduciary operating under a conflict of interest may be entitled to review by the arbitrary and capricious standard for its discretionary decisions as provided in the

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[14] This quotation omits the factor of "unanticipated costs" because that matter is considered before the focus shifts to the two mentioned factors.

[15] We previously have applied the *Restatement's* fourth factor without so stating. In *Helms v. Monsanto Co.*, 728 F.2d 1416, 1420-22 (11th Cir.1984), we used, as external standards to measure a fiduciary's plan interpretation of a disability provision, insurance policies with similar provisions and cases construing the Social Security disability provisions.

ERISA plan documents, but the degree of deference actually exercised in application of the standard will be significantly diminished. A court should not exercise de novo review, but the area of discretion to which deference is paid must be confined narrowly to decisions for which a conflicted fiduciary can demonstrate that it is operating exclusively in the interests of the plan participants and beneficiaries. Even a conflicted fiduciary should receive deference when it demonstrates that it is exercising discretion among choices which reasonably may be considered to be in the interests of the participants and beneficiaries. The fiduciary, however, should bear the burden of dispelling the notion that its conflict of interest has tainted its judgment. If the fiduciary carries this burden, the party challenging its action may still succeed if the action is arbitrary and capricious by other measures. This second level of evaluation is assisted somewhat by the narrowing of the justifications which the fiduciary may properly assert in defense of its actions.

APPLICATION

We turn to the application of the principles for review of Blue Cross' denial of Brown's claim for medical benefits. The district court, working from a highly deferential application of the arbitrary and capricious standard, concluded:

> After consideration of the statements of facts submitted by each party, the court finds that material issues are not in dispute. The medical plan expressly provides for preadmission certification unless the admission constitutes an emergency or is related to maternity care. Further, there is no dispute that plaintiff failed to

> acquire preadmission certification on both hospital admissions. The court notes that there is some evidence that the second admission might be treated as a continuation of the first admission which did satisfy the emergency condition for coverage. Further, the court notes that there is some evidence that the second admission was also an emergency, hence eligible for coverage under the terms of the Plan.
>
> The court finds, however, that a rational basis exists for Blue Cross' decision not to extend coverage to the second admission. There is substantial evidence to support the conclusion of the health care provider that there were two separate admissions and that the second admission did not constitute an emergency admission. Therefore, Blue Cross' denial of plaintiff's claim for benefits cannot be said to be arbitrary and capricious.

We cannot affirm this analysis, however, because the conflict of interest suffered by Blue Cross in this case demands closer scrutiny. Consistent with our test for the decisions of a fiduciary suffering from a conflict of interest we would require at this stage a demonstration that Blue Cross adopted its plan interpretations exclusively for the benefit of the plan participants and beneficiaries. The posture of the case does not permit our progress to the next stage. In the present case, then, we look ahead to see if Brown could prevail, should Blue Cross fail on remand to justify its actions. We conduct this inquiry to ascertain whether an alternative basis for affirming the district court is present. Our review of the record on appeal suggests that Brown may prevail if the arbitrary and capricious standard is applied with consideration for

Blue Cross' conflict of interest. We conclude remand is necessary to resolve this case.

Our analysis begins with two observations regarding the circumstances of Blue Cross' final benefit denial determinations. First, as we noted at the outset, Blue Cross initially denied coverage for both periods of hospitalization. Brown obtained payment of the first period only after pursuing review of that denial. This change in position highlights Blue Cross' conflict of interest and calls into question its motives in benefits determinations. The reversal of its denial of the claim for the first period of hospitalization was based on nothing more than the medical records from that time. Those records should have been part of a good faith determination at the outset. That Blue Cross would reach opposing conclusions on the basis of the same evidence seriously challenges the assumptions upon which deference is accorded to Blue Cross' interpretation of the plan. *Cf. Gunderson v. W.R. Grace & Co. Long Term Disability Income Plan*, 874 F.2d 496, 500 (8th Cir.1989) (no deference due to fiduciary's decision to deny benefits under second category of total disability where fiduciary previously found disability under other category based on same evidence and identical definition).

We further observe that Blue Cross does not contest that the surgery performed on Brown was medically necessary and that it would have been covered if preadmission certification had been obtained. Blue Cross, then, has interpreted the plan to work a forfeiture of benefits by Brown. As a general principle, employee benefit plans should not be interpreted in such a way as to produce a forfeiture. *See Helms v. Monsanto Co.*, 728 F.2d 1416, 1420

(11th Cir.1984) ("Congress wanted to assure those who participate in the plans actually receive the benefits they are entitled to and do not lose these as a result of unduly restrictive provisions or lack of sufficient funds."); *Bonar v. Barnett Bank*, 488 F.Supp. 365, 369 (M.D. Fla. 1980) (employer unilaterally establishes plan to encourage continued employment through promise of benefits, so terms should be construed in favor of employees to whom promises are made); *Russell v. Princeton Labs., Inc.*, 50 N.J. 30, 231 A.2d 800, 803 (1967) (pre-ERISA employee benefit plan case). Because Blue Cross profits from such forfeitures, we should demand strong justification for an interpretation which produces this result.

In light of these observations, we test Blue Cross' decisions by the arbitrary and capricious standard as appropriate in an instance for which conflicting interests are involved. Consistent with the methodology recommended by *Denton v. First National Bank of Waco*, 765 F.2d 1295, 1304 (5th Cir.1985), our first step in the application of arbitrary and capricious standard is determining the legally correct interpretation of the disputed plan provision. That is, we must determine if Brown has proposed a sound interpretation of the plan, one that can rival the fiduciary's interpretation. Thereafter we evaluate whether the fiduciary was arbitrary and capricious in adopting a different interpretation. *Id.*

Brown stands by two theories in support of his claim for benefits. The first theory posits that the second period of hospitalization is a continuation of the first. The district court concluded, as quoted above, that some evidence supported this theory. We agree. One indicator is Blue Cross' initial decision to lump the two periods

together. Another reason to treat the periods of hospitalization together is the treating physician's opinion that the two periods were a common admission. Materials submitted by Brown in opposition to the summary judgment motion suggest that he persuaded his doctors to allow him to go home for a few days in order to reduce his medical bills and to allow him to tend to matters at home.

The plan does not purport to define what constitutes a single admission for the purpose of an emergency.[16] Blue Cross exercised its general discretion in deciding that the admissions were separate. As noted previously, though, Blue Cross' position seems contrary to its consideration of the two periods of hospitalization together when the claim was initially denied in full.

Moreover, the discrete division of the two admissions gives rise to inconsistencies with other provisions of the plan. For instance, the plan limits the number of days for which major medical coverage is available during a single confinement to a hospital. *See* Contract Plan, § V(A)(1). It

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[16] The plan does provide a definition of emergency. *See* Contract Plan, § I(30) ("Medical Emergency"). An issue raised on appeal is whether Blue Cross has additional discretion because the definition adds "in the Company's judgment" to the definition of emergency. We are of the opinion that the issue is cut short by the omission of that phrase from the summary plan booklet. While Blue Cross argues that its absence is inconsequential because the summary refers participants to the full Contract Plan and states that the latter controls, we rejected this argument out of hand in *McKnight v. Southern Life & Health Insurance Co.*, 758 F.2d 1566, 1570 (11th Cir.1985), and Blue Cross has provided no basis for distinction to avoid the same fate here.

states, "Successive admissions to a hospital or hospitals shall be deemed to result in a 'single confinement' if discharged from and readmission to a hospital or hospitals occur within a 90 day period." *Id.* Blue Cross argues that this language is expressly limited to the definition for a confinement, not an admission. The distinction is illusory. We look to provisions such as Section V(A)(1) not to define conclusively other provisions. Rather, we seek objective guidance by which to measure the exercise of Blue Cross' discretion. The ninety-day standard indicates recognition of the continuing nature of many afflictions. Blue Cross may be able to explain why it is justified in treating Brown's readmission only three days after discharge differently from the conclusive presumption imposed in the plan for the limitation of benefits payable, but the need for that explanation bars us from affirming the grant of summary judgment.

The demand for preadmission certification for a second admission, when the second admission follows so quickly on the heels of a discharge from the hospital, also raises questions relative to the procedures for preadmission certification.[17] The plan describes the process as one

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[17] At oral argument appellant's counsel represented that oral approval of preadmission certification is commonplace. This variation from the plan document is not of record. Assuming for present purposes that oral approvals are used frequently, we did not find in this practice a basis to vary our analysis. Blue Cross must adopt interpretations of plan provisions which are consistent with the *written* terms of the plan. *Cf. Nachwalter v. Christie*, 805 F.2d 956 (11th Cir.1986); *Thomas v. Gulf Health Plan, Inc.*, 688 F.Supp. 590, 595 (S.D.Ala.1988). Blue

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in which the patient and physician fill out a written form, deliver it to Blue Cross and await written notice by mail

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Cross may not justify a plan interpretation on its consistency with actual practice when the interpretation is inconsistent with the written terms concerning the practice. *Cf. Kane v. Aetna Life Insurance*, 893 F.2d 1283, 1285-86 (11th Cir.1990) (federal common law of equitable estoppel applies to oral interpretations of plan, but oral representations may not amend or modify written terms of plan).

The matter of oral approval leads to an additional point raised by appellant. He asserts that the record shows that precertification was indeed obtained for the second admission. Several pieces of documentation available to Blue Cross at the time of its decision suggest his assertion could be true. First, a notation on Brown's hospital record for admission on September 29th lists Blue Cross' telephone number and "Pre-Cert with Judy." Second, a Blue Cross record of inquiry shows communication between Brown's hospital and Blue Cross on September 24th. This record mentions "PAC" and "hospital verification complete." Last, Brown's letter to Blue Cross dated March 2, 1988, states, in passing: "By the way Dr. Lupin informed me before any admittance to the Hospital they call Blue Cross, now I understand why I had to waite [sic] 2 hours before I was admitted the second time." One inference that might be culled from these documents is that a call was made and preadmission certification was obtained. Another inference is that Blue Cross acted arbitrarily and capriciously in denying Brown's claim if it did not further pursue the possibility that oral certification was validly given.

We cannot, however, grant relief to Brown on the basis of a question of material fact concerning whether preadmission certification was obtained. His counsel admitted at oral argument that he did not present any argument to the district court on the matter of having obtained PAC. We will not disturb the

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from the insurance company. *See* Contract Plan, § V(A)(5). Should a patient who is discharged on a Saturday with instructions from his doctor to return on the following Wednesday expect that the planned surgery must be subjected to what appears to be a time-consuming process of preadmission approval? Of course, the subjective expectations of plan participants and beneficiaries are not the measure of a reasonable plan interpretation. *See Hoover*, 855 F.2d at 1542. But we juxtapose the definitions of "emergency" and the procedure for preadmission certification and find that a reasonable person could conclude that the short period of discharge from the hospital did not interrupt an emergency admission for which certification was not necessary.[18] Thus, Blue Cross' discretion

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(Continued from previous page)

district court's grant of summary judgment on the basis of an argument not addressed to that forum. *See Denis v. Liberty Mutual Ins. Co.*, 791 F.2d 846, 848-49 (11th Cir.1986).

Since we reverse and remand on other grounds, we do not perceive any bar to the assertion of this theory on remand since the relevant documentation was before the district court. As the exchange of oral argument revealed, though, additional discovery is undoubtedly needed in order for Brown to prevail on this theory.

[18] Brown's correspondence with Blue Cross details his perspective on his admission, discharge, and readmission. Brown reports that prior to discharge he had been taken off of intravenous antibiotics and placed on an oral schedule of the same medication. His physician hesitated to discharge him because failure to follow a precise schedule in taking the medication could reignite the symptoms that led to Brown's admission. If Brown can prove these allegations at trial, then there appears a solid factual basis for his theory of treating the two periods of hospitalization as one.

under the plan is bounded by an external standard that assists in the interpretation of an emergency. An interpretation to the contrary requires solid justification from Blue Cross and, in the absence of such justification, we cannot affirm the grant of summary judgment.

Brown's second theory describes his second admission to the hospital as an independent emergency. From a purely medical perspective we find no fault in Blue Cross' rejection of this theory. Brown's doctor wrote a letter setting forth symptoms indicative of an emergency. Blue Cross' expert compared the description in the letter with the medical records prepared at the time of Brown's admission. The two sources conflicted. Blue Cross prudently solicited additional information from the physician-author of the letter. When no reply was forthcoming, Blue Cross preferred the contemporaneously prepared evidence over the letter written much after the fact. Even a self-interested fiduciary is entitled to choose an apparently more reliable source of information when sources conflict.[19]

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[19] We stress the request for further information as an indicator of Blue Cross' good faith in resolving this narrow question. The fact that Blue Cross showed good faith in one aspect of its consideration of Brown's claim is not enough to impute good motives to their entire consideration of his claim. The self-interest under which Blue Cross operates may not manifest itself in conscious favoritism of its interests over Brown's. Consequently, Blue Cross may act in good faith in one respect and subconsciously advance its interests in another respect. In this case, for example, there is little indication that Blue Cross gave serious consideration to Brown's adamant advocacy of the single admission theory.

From a plan interpretation standpoint, however, we would hold Blue Cross to task for adopting a construction that places a beneficiary in an untenable position. Assuming Blue Cross is correct in treating the second admission as distinct, then the beneficiary must seek preadmission certification. Those procedures, however, do not lend themselves to accomplishment in the few days prior to readmission. Blue Cross, then, must expect the beneficiary to dispute his doctor's judgment, following a five-day hospitalization for an emergency, that surgery should take place so soon. Instead, the beneficiary is expected to seek a delay until preadmission certification is obtained. Such a rule seems dangerous if not wholly absurd. Perhaps Blue Cross can explain its position to the district court; its opportunity is presented on remand.

CONCLUSION

The district court correctly noted that some evidence supports Brown's arguments favoring coverage. This evidence must be evaluated within the framework of the arbitrary and capricious standard, as it applies when the circumstances of the fiduciary's discretionary action invoke well-established common-law principles suggesting the potential abuse of discretion in the administration of a trust. In accordance with our foregoing analysis, we REVERSE the grant of summary judgment by the district court and REMAND for proceedings not inconsistent with this opinion.

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ALABAMA
Southern Division

FRED BROWN,	)	
	)	
Plaintiff,	)	Case No.
-vs.-	)	88-P-1616-S
	)	
BLUE CROSS AND BLUE SHIELD OF ALABAMA, INC., a corporation; TRUCK RENTALS OF ALABAMA, INC., a corporation, et al.,	)	
	)	
Defendants.	)	

OPINION

(Filed Feb. 2, 1989)

The above-styled action is before the court on defendants' motion for summary judgment. This case involves the denial of a claim for health benefits under an employee welfare plan regulated by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 *et seq.*. Under ERISA, the determination of a claim for benefits, made by the administrator of an employee benefit plan, must be upheld unless the decision is arbitrary and capricious or made in bad faith.

Plaintiff was a participant in an employee benefit plan maintained by his employer, Truck Rentals of Alabama through Baggett Transportation Company. Blue Cross and Blue Shield of Alabama is the claims administrator for this plan ("Blue Cross"). Under the terms of the plan, preadmission certification is required for all inpatient hospital admissions except for emergency or maternity admissions. Medical emergency is defined under this

Plan as "a sudden and unexpected onset of a medical condition the symptoms of which are acute and of such severity as to require, in the Company's judgment, immediate medical and attention to prevent permanent danger to the health, other serious medical results, serious impairment to bodily function or serious and permanent lack of function of any bodily organ or part of a Member." (§ I.30, Defendant Exhibit A at 5) Specifically, the Plan provides that no benefits shall be provided for "[s]ervices or expenses furnished to a Member for or during a Hospital admission or stay for other than Medical Emergency or maternity care unless the Company has approved and precertified the admission and stay before the Member was admitted in accordance with Section V.A.5." (§ 6.B.36, Defendant Exhibit A at 26.) Further, the Summary Plan Description, members are advised that "[p]readmission Certification is required for all hospital admissions except emergency and maternity admissions." (Defendant Exhibit B at 5.)

Plaintiff was admitted to St. Charles General Hospital in New Orleans, Louisiana on two separate occasions for treatment of a sinus condition. The first admission was on September 21, 1987, and the second admission was on September 29, 1987. Preadmission certification was not obtained for either of these admissions. Following a review of the medical records concerning both admissions, Blue Cross determined that only the first admission constituted a medical emergency, hence qualifying for medical coverage in accordance with the terms of the Plan.

Plaintiff argues that both admissions were emergencies and that defendant was arbitrary and capricious in

denying coverage for the second admission. In the alternative, plaintiff argues that there was only one admission which related to his sinus condition. The "readmission" was a continuation of the first admission which had already been determined to have been an emergency. Consequently, Blue Cross should extend coverage for surgery, performed during his second stay at the hospital, since this procedure had been prescribed during his initial stay.

After consideration of the statements of facts submitted by each party, the court finds that material issues are not in dispute. The medical plan expressly provides for preadmission certification unless the admission constitutes an emergency or is related to maternity care. Further, there is no dispute that plaintiff failed to acquire preadmission certification on both hospital admissions. The court notes that there is some evidence that the second admission might be treated as a continuation of the first admission which did satisfy the emergency condition for coverage. Further, the court notes that there is some evidence that the second admission was also an emergency, hence eligible for coverage under the terms of the Plan.

The court finds, however, that a rational basis exists for Blue Cross' decision not to extend coverage to the second admission. There is substantial evidence to support the conclusion of the health care provider that there were two separate admissions and that the second admission did not constitute an emergency admission. Therefore, Blue Cross' denial of plaintiff's claim for benefits cannot be said to be arbitrary and capricious. *See Griffis v. Delta Family-Care Disability*, 723 F.2d 822 (11th Cir. 1984)

(to disturb decision of the committee administering employee benefits plan, plaintiff must establish that decision was arbitrary or capricious). Accordingly, defendants' motion for summary judgment is due to be GRANTED.

This the 2nd day of February, 1989.

/s/ Sam C. Pointer, Jr.
United States District Judge

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

NO. 89-7151

FRED BROWN,

Plaintiff-Appellant,

versus

BLUE CROSS AND BLUE SHIELD OF ALABAMA, INC., a corporation; TRUCK RENTALS OF ALABAMA, INC., a corporation; et al.,

Defendants-Appellees.

Appeal from the United States District Court for the Northern District of Alabama

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ON PETITION(S) FOR REHEARING AND SUGGESTION(S) OF REHEARING IN BANC
(Opinion April 25, 1990, 11 Cir., 198 , ___F.2d___).
(June 19, 1990)

Before JOHNSON, Circuit Judge, RONEY*, Senior Circuit Judge, and MELTON**, District Judge.

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*See Rule 34-2(b), Rules of the U.S. Court of Appeals for the Eleventh Circuit.

**Honorable Howell W. Melton, U.S. District Judge for the Middle District of Florida, sitting by designation.

PER CURIAM:

(✔) The Petition(s) for Rehearing are DENIED and no member of the panel nor other Judge in regular active service on the Court having requested that the Court be polled on rehearing in banc (Rule 35, Federal Rules of Appellate Procedure; Eleventh Circuit Rule 35-5) the Suggestion(s) of Rehearing In Banc are DENIED.

( ) The Petition(s) for Rehearing are DENIED and the Court having been polled at the request of one of the members of the Court and a majority of the Circuit Judges who are in regular active service not having voted in favor of it (Rule 35, Federal Rules of Appellate Procedure; Eleventh Circuit Rule 35-5), the Suggestion(s) of Rehearing In Banc are also DENIED.

( ) A member of the Court in active service having requested a poll on the reconsideration of this cause in banc, and a majority of the judges in active service not having voted in favor of it, Rehearing In Banc is DENIED.

ENTERED FOR THE COURT:

/s/ Frank M. Johnson, Jr.
United States Circuit Judge

No. 90-494

IN THE
Supreme Court of the United States
OCTOBER TERM, 1990

BLUE CROSS AND BLUE SHIELD OF ALABAMA and
TRUCK RENTALS OF ALABAMA, INC.,
Petitioners,

v.

FRED BROWN,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

MOTION FOR LEAVE TO FILE BRIEF AMICI CURIAE AND BRIEF AMICI CURIAE FOR THE AMERICAN COUNCIL OF LIFE INSURANCE AND THE HEALTH INSURANCE ASSOCIATION OF AMERICA IN SUPPORT OF THE PETITION

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MOTION FOR LEAVE TO FILE BRIEF AMICI CURIAE FOR THE AMERICAN COUNCIL OF LIFE INSURANCE AND THE HEALTH INSURANCE ASSOCIATION OF AMERICA IN SUPPORT OF THE PETITION

The American Council of Life Insurance ("ACLI") and the Health Insurance Association of America ("HIAA") hereby move, pursuant to Rule 37.2 of the Rules of this Court, for leave to file the attached brief as *amici curiae*. Counsel for the petitioner has consented to the filing of this brief; counsel for the respondent has refused consent.

The ACLI is the largest life insurance trade association in the United States, representing the interests of 616 member life insurance companies. The ACLI's members currently hold 95 percent of the life insurance in force in legal reserve life insurance companies in the

United States. The HIAA represents the interests of 320 member companies that write over 85 percent of the health insurance written by commercial insurance companies in the United States; the HIAA's members provide health insurance coverage to approximately 95 million Americans.

The issue presented in this case—whether a court, reviewing a discretionary decision of an insurer to deny a claim for benefits under an insured employee benefit plan, must conclude that a reasonable decision is nonetheless "arbitrary and capricious" unless the insurer proves that its decision was not tainted by a conflict of interest—is vitally important to the members of the ACLI and HIAA. In 1989, at least 34 percent of health plan participants in the United States received coverage under plans funded through the purchase of group insurance policies; another 19 percent of such participants received coverage through Blue Cross-Blue Shield plans. *See Employee Benefits in Medium and Large Firms, 1989*, U.S. Department of Labor, Bureau of Labor Statistics, Bulletin 2363 (June 1990), at 39; *see also* Employee Benefit Research Institute, *EBRI Databook on Employee Benefits* (1990), at 216. Under many of these plans, the insurers have discretionary authority to process claims and interpret plan terms. Thus, the decision below, which applies a more stringent standard of review to the decisions of insurer/claims-fiduciaries of insured plans than to fiduciaries of self-insured plans, has an immediate and direct impact on the members of the ACLI and the HIAA.

Because of their nationwide constituencies, the ACLI and the HIAA are uniquely able to provide this Court with the views of the life and health insurance industries concerning the issue presented in this case and to offer additional arguments underscoring the importance of this Court's review. In other cases impacting the role that insurers play under the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.*

("ERISA"), the ACLI and the HIAA have filed *amici* briefs in this Court. *See, e.g., Firestone Tire & Rubber Co. v. Bruch*, 109 S. Ct. 948 (1989); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985). For these reasons, the Court should grant this motion for leave to file the attached brief *amici curiae* in support of the Petition.

Respectfully submitted,

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October 1990

QUESTION PRESENTED

Whether a court, reviewing a discretionary decision of an insurer to deny a claim for benefits under an insured employee benefit plan, must conclude that a reasonable decision is nonetheless "arbitrary and capricious" unless the insurer proves that its decision was not tainted by a conflict of interest.

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OCTOBER TERM, 1990

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---

BRIEF AMICI CURIAE FOR THE AMERICAN COUNCIL OF LIFE INSURANCE AND THE HEALTH INSURANCE ASSOCIATION OF AMERICA IN SUPPORT OF THE PETITION

INTERESTS OF THE AMICI

As stated in the motion accompanying this *amici* brief, the American Council of Life Insurance ("ACLI") is the largest life insurance trade association in the United States, representing the interests of 616 member life insurance companies. The ACLI's members currently hold 95 percent of the life insurance in force in legal reserve life insurance companies in the United States.

The Health Insurance Association of America ("HIAA") represents the interests of 320 member companies that write over 85 percent of the health insurance written by commercial insurance companies in the United States.

Defining the appropriate standard of judicial review for decisions of insurer/claims-fiduciaries of insured employee benefit plans, where those plans vest the insurer with discretionary authority, is critically important to the members of the ACLI and HIAA. In 1989, over half of the health plan participants in the United States received coverage under plans funded through the purchase of group policies from commercial insurance companies and Blue Cross-Blue Shield. *See Employee Benefits in Medium and Large Firms, 1989*, U.S. Department of Labor, Bureau of Labor Statistics, Bulletin 2363 (June 1990), at 39; *see also* Employee Benefit Research Institute, *EBRI Databook on Employee Benefits* (1990), at 216. Under many of these plans, the insurers have discretionary authority to process claims and interpret plan terms. The decision below thus directly impacts the members of the ACLI and HIAA.

This brief is filed to provide the Court with the unique perspectives of the ACLI and HIAA, based on the experiences of their broad-based constituencies, concerning the appropriate standard of review of insurer/claims-fiduciary decisions under the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* ("ERISA") and to offer additional arguments to underscore the importance of this Court's review.

STATEMENT

1. This case involves a decision of Blue Cross and Blue Shield of Alabama ("Blue Cross") to deny a claim for benefits under an employer-sponsored welfare benefit plan (the "Plan"). Respondent's employer, Truck Rentals of Alabama, Inc. ("Truck Rentals"), provides health insurance benefits to its employees through the purchase of insurance from Blue Cross (Pet. App. A-2). The Plan, which vests Blue Cross with claims-handling authority, provides that "whenever [Blue Cross] makes reasonable determinations which are not arbitrary and capricious in the administration of the [plan] . . . , such determinations shall be final and conclusive" (*id.* at A-6).

In September 1987, respondent entered the hospital twice for a sinus condition (Pet. App. A-2). During his first visit, respondent underwent tests and received treatment for his immediate symptoms; he entered the hospital a second time, three days after his first hospital release, to obtain surgical treatment of his sinus condition (*id.*). Respondent pre-certified neither hospital visit, even though the Plan required pre-certification for all non-emergency hospitalizations (*id.*).

Based on its interpretation of the Plan's terms, Blue Cross treated respondent's first hospitalization as a "medical emergency" and, despite his failure to pre-certify, reimbursed him for the costs associated with this hospitalization (Pet. App. A-2). Because respondent failed to pre-certify his second hospital visit, which Blue Cross considered a non-emergency, Blue Cross denied his claim for benefits associated with that hospitalization (*id.* at A-2 - A-3).

2. Respondent sued Blue Cross and Truck Rentals to compel the payment of benefits under the Plan (Pet. App. A-3). Reviewing Blue Cross' denial of benefits under an "arbitrary and capricious" standard, the United States District Court for the Northern District of Ala-

bama found that "a rational basis exists for Blue Cross' decision not to extend coverage to the second admission" and, accordingly, sustained that decision (*id.* at A-41).

3. The Eleventh Circuit reversed. The court initially concluded that the Plan gave Blue Cross discretionary decision-making authority and, therefore, compelled the application of an "arbitrary and capricious" standard of review (Pet. A-5 - A-7, *citing Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 S. Ct. 948 (1989)). The court nonetheless concluded that the district court's application of a "highly deferential" standard of review was improper because of the "inherent conflict between the fiduciary role and the profit-making objective of an insurance company" (*id.* at A-12). The court thus articulated a rule to govern judicial review of discretionary decisions of insurer/claims-fiduciaries that "is shaped by th[is] . . . inherent conflict of interest" (*id.* at A-16):

> [W]hen a plan beneficiary demonstrates a substantial conflict of interest on the part of the fiduciary responsible for benefit determinations, the burden shifts to the fiduciary to prove that its interpretation of plan provisions committed to its discretion was not tainted by self-interest. That is, a wrong but apparently reasonable interpretation is arbitrary and capricious if it advances the conflicting interest of the fiduciary at the expense of the affected beneficiary or beneficiaries unless the fiduciary justifies the interpretation on the ground of its benefit to the class of all participants and beneficiaries.

Id. at A-24 - A-25. Only if the fiduciary meets this burden, the court continued, does the "focus move[] then to the familiar ways to test the fiduciary's decision against the arbitrary and capricious standard" (*id.* at A-28).

REASONS FOR GRANTING THE WRIT

I. THE FEDERAL COURTS OF APPEALS HAVE ADOPTED VARYING APPROACHES IN REVIEWING DISCRETIONARY DECISIONS OF ERISA PLAN FIDUCIARIES UNDER THE "ARBITRARY AND CAPRICIOUS" STANDARD SINCE THIS COURT'S DECISION IN *FIRESTONE TIRE & RUBBER CO. v. BRUCH*

In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 S. Ct. 948, 956 (1989), this Court held that a denial of a claim for benefits under an ERISA-covered plan "is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." The Court made clear in *Firestone* that application of the *de novo* standard obviated the need to "distinguish between types of plans" or to determine "whether the administrator or fiduciary is operating under a possible or actual conflict of interest." *Id.* The Court, however, indicated that these factors could still be relevant when the plan vests a fiduciary with discretion to make benefit determinations. Thus, the Court explained that "if the benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'factor[] in determining whether there is an abuse of discretion.'" *Id.*, *quoting* Restatement (Second) of Trusts § 187, Comment *d* (1959).

Since this Court's decision in *Firestone*, the federal courts of appeals have varied in their application of the "abuse of discretion" standard to decisions of fiduciaries exercising discretionary authority under a plan. Where the interests of the decision-making fiduciaries obviously do not conflict with those of participants and beneficiaries, the courts have predictably deferred to reasonable fiduciary decisions under an "abuse of discretion" or "arbitrary and capricious" standard. *See, e.g., Exbom v.*

Central States, Southeast & Southwest Areas Health & Welfare Fund, 900 F.2d 1138 (7th Cir. 1990) (court deferred to denial of health benefits by board of trustees comprised of equal number of employer and union trustees); *Jones v. Laborers Health & Welfare Trust Fund*, 906 F.2d 480 (9th Cir. 1990) (same); *Bali v. Blue Cross and Blue Shield Ass'n*, 873 F.2d 1043 (7th Cir. 1989) (court deferred to denial of employee's claim for benefits where decision-maker was neither the insurer nor the employer); *see also Jett v. Blue Cross & Blue Shield of Alabama*, 890 F.2d 1137 (11th Cir. 1989) (arbitrary and capricious standard applies to decision of insurer administrator of self-insured plan). But, where the decision-makers wear "two hats," courts have adopted varying approaches in reviewing their discretionary decisions.

On one hand, courts have deferred to the decisions of plan administrators who simultaneously serve as both employees of the plan sponsor and claims-fiduciaries. In *De Nobel v. Vitro Corp.*, 885 F.2d 1180 (4th Cir. 1989), for example, the Fourth Circuit upheld the decision of the employee-administrators to deny enhanced retirement benefits to certain participants in a defined benefit pension plan, holding that courts cannot overturn as an "abuse of discretion" benefit determinations based on a fiduciary's " 'reasonable interpretation' of disputed provisions." *Id.* at 1188 (citations omitted). In applying this deferential standard, the Fourth Circuit declined to "attribute 'presumptive bias' to the administrators—notwithstanding that they serve dual roles as company employees and pension plan fiduciaries." *Id.* at 1191; *see also Davis v. Kentucky Finance Cos. Retirement Plan*, 887 F.2d 689, 694 (6th Cir. 1989) (conflict of interest of employee-administrator is only one factor in determining whether decision was arbitrary and capricious), *cert. denied*, 110 S. Ct. 1924 (1990). Other courts, prior to this Court's decision in *Firestone*, had similarly applied this deferential "arbitrary and capricious" stand-

ard to the decisions of employer-appointed fiduciaries of employer-funded plans. *See, e.g., Van Boxel v. Journal Company Employees' Pension Trust*, 836 F.2d 1048, 1050-53 (7th Cir. 1988); *Jung v. FMC Corp.*, 755 F.2d 708, 711 (9th Cir. 1985).[1]

In contrast, the Eleventh Circuit has been unwilling to defer to the decisions of insurer representatives who similarly wear two hats. In the instant case, the court of appeals concluded that, unlike the decisions of the employee-administrators in *De Nobel*, the decisions of fiduciaries of insured plans, who serve as both representatives of the insurer and claims-handling fiduciaries, "inherently implicate the hobgoblin of self-interest" (Pet. App. A-27). It thus held that this "perpetual conflict" precludes reliance on a deferential standard of review and shifts the burden to the insurer-fiduciary to dis-

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[1] A defined benefit plan, like that at issue in *De Nobel*, provides a fixed level of pension benefits to plan participants. *See Mead Corp. v. Tilley*, 109 S. Ct. 2156, 2159 (1989). Under such plans, the employer is responsible for making whatever plan contributions are necessary to fund the benefits on an actuarially-sound basis; the employer, who assumes the risk of the plan's actuarial experience, must make up any shortfall in plan assets resulting from adverse actuarial experience. *See Nachman Corp. v. PBGC*, 446 U.S. 359, 363-64 n.5 (1980); *Blessitt v. Retirement Plan*, 848 F.2d 1164, 1177 (11th Cir. 1988) (en banc). Thus, while a fiduciary's claims decisions do not have an immediate impact on the employer-sponsor of such defined benefit plans, those decisions do financially affect the employer to the extent that claims payments exceed actuarially-anticipated amounts and require increased employer contributions. *See Van Boxel v. Journal Company Employees' Pension Trust*, 836 F.2d 1048 (7th Cir. 1988); *Lowry v. Bankers Life & Casualty Retirement Plan*, 871 F.2d 522, 525-26 n.7 (5th Cir. 1989), *cert. denied*, 110 S. Ct. 152 (1989). This arrangement has prompted at least one author to question the impartiality of decision-makers who are "'creatures' of the employer who appoints them, [who] generally employs them, and who may remove them at will" and thus "are typically not the loyal trustees for participants and beneficiaries that the common law of trusts envisions." Bruce, *Pension Claims: Rights and Obligations* (BNA 1988) 311.

prove the taint of self-interest (*id.* at A-24 - A-25). Under the Eleventh Circuit's test, therefore, courts can defer to a "wrong but apparently reasonable interpretation" under the arbitrary and capricious standard *only* if the "interested" fiduciary "justifies its interpretation on the ground of its benefit to the class of all participants and beneficiaries" (*id.*). *See also Anderson v. Blue Cross/Blue Shield of Alabama*, 907 F.2d 1072, 1076 (11th Cir. 1990) (describing *Brown* standard as similar to *de novo* review); *Newell v. Prudential Ins. Co.*, 904 F.2d 644, 651 (11th Cir. 1990) (applying *Brown* standard); *but see Pierre v. Connecticut General Life Ins. Co.*, 866 F.2d 141, 143 (5th Cir. 1989) (without addressing *Firestone*, court concluded that arbitrary and capricious standard applies when insurer is the decision-making fiduciary despite potential self-interest).[2]

The Eleventh Circuit's formulation of the "arbitrary and capricious" standard—which elevates "conflict of interest" to more than merely "a factor" in judicial review (*Firestone Tire & Rubber Co. v. Bruch*, 109 S. Ct. at 956)—thus departs markedly from the deferential review standard that the Fourth Circuit applied in *De Nobel* to "interested" decision-makers. While the decision-makers in both the instant case and *De Nobel* had, as fiduciaries, a duty of loyalty to plan participants and beneficiaries (*see* 29 U.S.C. § 1104), they both also served as employees of an interested entity. Here, the decision-makers were employees of an insurer who paid benefits out of the insurer's assets in exchange for the plan sponsor's payment of experience-rated premiums; in *De Nobel*, the decision-makers were employees of a plan sponsor who was responsible for ensuring, through plan

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[2] As the *amici* explain in Part II of this brief, it is not at all clear that such a "perpetual conflict" actually exists in cases where an insurance company both insures a plan and makes claims decisions. *See* discussion, *infra*, at 10-12. Such a conflict, if it exists at all, is quite attenuated. *Id.*

contributions, an adequate level of funds to pay benefits. While the Fourth Circuit refused to find "presumptive bias" in the actions of the "interested" decision-makers in *De Nobel* (considering bias, instead, as one factor in its review), the Eleventh Circuit here applied precisely such a presumption—it shifted the burden to the insurer/claims-fiduciary to disprove its bias and conditioned resort to traditional, multi-factored "arbitrary and capricious" review on that proof.

The decision below thus spawns confusion concerning the proper application of the "abuse of discretion" standard and undermines the concern for uniformity that motivated Congress to establish a federal fiduciary standard in ERISA. In describing the need for such a standard, Congress explained that certain plans—like insured plans—were not structured as "trusts" and, accordingly, had not been subject to trust law principles. *See* H. Rep. No. 533, 93d Cong., 1st Sess. 11-12 (1973), *reprinted in* 2 *Legislative History of the Employee Retirement Income Security Act ("Legislative History")* 2348, 2358-59 (Comm. Print 1976). Congress thus adopted a uniform, federal fiduciary standard applicable to *all* covered plans, regardless of their method of funding:

> [A] fiduciary standard embodied in Federal legislation is considered desirable because it will bring a measure of uniformity in an area where decisions under the same set of facts may differ from state to state. . . . [I]t is evident that the operations of employee benefit plans are increasingly interstate. The uniformity of decision which the Act is designed to foster will help administrators, fiduciaries and participants to predict the legality of proposed actions without the necessity of reference to varying state laws.

Id. at 12, *reprinted* in 2 *Legislative History* 2359. *See also* S. Rep. No. 127, 93d Cong., 1st Sess. 35 (1973), *reprinted in* 1 *Legislative History* 587, 621 ("Because of the interstate character of employee benefit plans, the

Committee believes it is essential to provide for a uniform source of law . . . for evaluating fiduciary conduct").

The decision below plainly jeopardizes this uniformity in decision-making that Congress sought to ensure when it enacted ERISA. While this Court in *Firestone* provided needed guidance concerning the proper application of the *de novo* standard of review of fiduciary decisions, the Court had no opportunity to define the parameters of the "abuse of discretion" standard. This case presents an opportunity for the Court to do so and, at the same time, to "bring a measure of uniformity" to judicial review of discretionary decisions of plan fiduciaries. *See* H. Rep. No. 533, 93d Cong., 1st Sess. 12 (1973), *reprinted in* 2 *Legislative History* 2359.

II. THE DECISION BELOW CREATES AN UNTENABLE DISTINCTION BETWEEN INSURED AND SELF-INSURED PLANS FOR PURPOSES OF JUDICIAL REVIEW OF DISCRETIONARY DECISIONS OF PLAN FIDUCIARIES

The court below recognized that its formulation of the "arbitrary and capricious" standard of review "draw[s] a distinction between plans that are truly trusts and plans that are based solely on contracts or policies for insurance" (Pet. App. A-27), imposing on the latter plans the substantial burden of dispelling the taint of self-interest "inherent" in the actions of insurer/claims-fiduciaries. That distinction, however, misconstrues the function of insured plans and undermines their important role under ERISA.

The court of appeals' pronouncement that an insurer's "fiduciary role lies in perpetual conflict with its profit-making role as a business" (Pet. App. A-11) plainly misperceives the operation of insured plans under ERISA. ERISA makes clear that employers can fund welfare benefits for their employees "through the purchase of in-

surance . . ." (29 U.S.C. § 1002(1)); it also makes clear that its fiduciary standards apply to claims-handling fiduciaries of these insured plans, just as they apply to fiduciaries of self-insured plans (*id.*, § 1104(a); *see also* H. Rep. No. 533, 93d Cong., 1st Sess. 11-12 (1973), *reprinted in* 2 *Legislative History* 2358-59). Consistent with these provisions, therefore, employers and insurers have structured insurance arrangements that, in operation, minimize the potential for a "conflict of interest" in the decisions of insurer/claims-fiduciaries. Indeed, because of the structure of these plans, "it is not at all clear that such conflict normally exists at all" (Mandel, *Must Claims Denials Be Upheld Unless Arbitrary and Capricious—What Standard of Review Applies to Group Policies Issued to ERISA Plans?*, 19 FORUM 457, 464 (Spring 1984):

> Many group insurance policies are experience rated, have retrospective premium provisions, are excess risk, or involve some combination of the foregoing. Experience rated means that premiums increase or decrease, in large part, depending on actual claims experience. Retrospective premium provisions allow the insurer, after the year is over, to retroactively increase premiums (up to specified levels) to make up any losses. Excess risk policies involve employer liability until certain 'trigger points' are reached, with insurer liability applying to claims processed after that point is reached. *All of these arrangements can readily lead to situations where an insurer has no direct financial interest in whether it pay[s] or denies a claim, but really functions more as a claim administrator and means for regulating cash flow.*

Id., 464 n.43 (emphasis added).

The premise for the court of appeals' application of essentially *de novo* review to an insurer/claims-fiduciary's discretionary decisions—that the insurer operates with an "inherent" or "perpetual" conflict of interest—is thus fundamentally unsound. Payments of claims under insured plans do not, as the court below suggests, result

in an unrecoverable, dollar-for-dollar depletion of the insurer's own assets. To the contrary, the insurer/claims-fiduciary pays these claims under a contract that is experience-rated, so that the insurer may increase or decrease employer premiums to account for actual claims experience. The risk that the insurer/claims-fiduciary will deny claims arbitrarily due to an inherent bias is, accordingly, likely to be no greater—and perhaps even less—than the risk that an employer-fiduciary would arbitrarily deny claims under a self-funded plan. *Cf. Van Boxel v. Journal Company Employees Pension Trust*, 836 F.2d 1048, 1051 (7th Cir. 1988) (risk that company-appointed trustees would act disloyally to participants is usually minimal).[3] While that risk is, of course, a factor in evaluating the insurer/claims-fiduciary's decision under the "abuse of discretion" standard (*see Firestone Tire & Rubber Co. v. Bruch*, 109 S. Ct. at 956), it is not the only—much less the determining—factor in reviewing such a decision. *See* Restatement (Second) of Trusts, § 187, Comment *d* (1959) (reciting factors).

The court of appeals' decision to subject insurer/claims-fiduciaries to such stringent judicial oversight, moreover, defeats the expectations of parties who contractually agree that the fiduciary's "reasonable" decisions are final and binding. In *Firestone*, this Court recognized that "a concern for impartial decisionmaking . . . [does not] foreclose[] parties from agreeing upon a narrow[] standard of review." 109 S. Ct. at 956. Employers who do so through unequivocal plan language, delegating binding claims-handling authority to the insurer, thus expect the benefit of their bargain. They expect the insurer to fulfill its fiduciary and contractual duty to engage in "reason-

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[3] Insurance companies, moreover, face substantial marketplace disincentives to deny valid claims arbitrarily. An arbitrary claims-handling record inevitably leads to disgruntled participants and, as a result, to disgruntled plan sponsors. To the extent that a particular insurer thus fails to satisfy these plan sponsors, they will simply take their business elsewhere.

able" decision-making and, through appropriate process, to issue determinations that, if reasonable, are final and binding. They should not have to expect that, just because they chose to fund their plans "through the purchase of insurance" (29 U.S.C. § 1002(1)), the contracting insurer will repeatedly have to litigate in the courts whether its reasonable determinations are nonetheless "arbitrary and capricious"—a scenario that can only mean increased administrative costs to the insurer, increased premiums for the employer, and added burdens on the courts. *See Hoiland v. Burlington Industries, Inc.*, 772 F.2d 1140, 1148 (4th Cir. 1985) (arbitrary and capricious standard "ensure[s] that primary responsibility rests with administrators 'whose experience is daily and continual, not with judges whose exposure is episodic and occasional' ") (citation omitted), *aff'd mem. sub nom., Brooks v. Burlington Industries, Inc.*, 477 U.S. 901 (1986).

The decision below, therefore, will inevitably burden the creation and maintenance of insured plans. Indeed, the court below noted that "one reason for limiting the deference when a fiduciary suffers a conflict of interest is *to discourage arrangements where a conflict arises*" (Pet. App. A-21; emphasis added)—in the court's view, where an insurer both insures the plan and processes claims. But discouraging employers who cannot afford to self-insure from providing employee benefits through the only feasible means available to them—through the purchase of insurance—threatens the security of thousands of beneficiaries who depend on employer-sponsored insurance. That threat is substantial. In 1989, at least 34 percent of health plan participants in the United States received coverage under commercially-insured plans; an additional 19 percent of these participants received coverage under Blue Cross-Blue Shield plans. *See Employee Benefits in Medium and Large Firms, 1989*, U.S. Department of Labor, Bureau of Labor Statistics, Bulletin 2363 (June 1990), at 39. This means that, in

1989, *over half* of this country's health plan participants depended on insurance arrangements for their benefits. *Id.*

Only this Court can authoritatively define the parameters of the "abuse of discretion" standard—as it applies to both insured and self-insured plans—and alleviate the disparate burden that the decision below places on the former plans. The question is a relatively simple one. It is one that is oft-recurring and thus adds to the volume of litigation in the lower courts. It is a clear example of the sort of case where this Court's review will contribute substantially both to the uniformity sought by Congress and to reducing the workload of the federal courts. The Court should, therefore, grant review.

CONCLUSION

The petition for certiorari should be granted.

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October 1990

(3)

No. 90-494

In The

Supreme Court of the United States

October Term, 1990

BLUE CROSS AND BLUE SHIELD OF ALABAMA
and TRUCK RENTALS OF ALABAMA, INC.,

Petitioners,

vs.

FRED BROWN,

Respondent.

Petition For A Writ Of Certiorari
To The United States Court Of Appeals
For The Eleventh Circuit

BRIEF IN OPPOSITION

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QUESTION PRESENTED

Whether the Eleventh Circuit created a new standard of judicial review in its decision in the case below.

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No. 90-494

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**Petition For A Writ Of Certiorari
To The United States Court Of Appeals
For The Eleventh Circuit**

BRIEF IN OPPOSITION

Respondent, Fred Brown, respectfully submits that a writ of certiorari to review the judgment and opinion of the United States Court of Appeals for the Eleventh Circuit entered in the above-entitled proceeding on April 25, 1990 should be denied.

STATEMENT OF THE CASE

Respondent hereby adopts the statement of the case as submitted by petitioners with the following exceptions:

1. At footnote number 3, page 7, Blue Cross asserts for the very first time what Blue Cross perceives as the two reasons for requiring pre-certification. Most insurance people would probably assert cost containment as the primary reason for requiring pre-certification. However, even accepting *both* of Blue Cross's self-serving reasons, neither reason would be applicable to the facts in the instant case. Blue Cross has never asserted that Brown's treatment was medically *un*necessary nor that the expenses were *un*reasonable. It is also undisputed that Brown would have incurred the expense without reference to pre-certification. There is no claim that the surgery performed on Brown could have been done on an outpatient basis. Blue Cross **CLAIMS** pre-certification was not obtained and the trial court labelled that claim as "undisputed," even though there is evidence in the record to the contrary.

2. On page 7, Blue Cross asserts that Blue Cross rejected Brown's claim for benefits after **EXTENSIVE** review of the medical records. The record reflects that Blue Cross reviewed **CERTAIN** medical records but ignored certain other medical records, although all were clearly in Blue Cross's file at the time of the denial of Brown's benefits.

3. On page 7, Blue Cross asserts that there was **NO EVIDENCE** of a medical emergency on the second admission. The trial court found " . . . there **IS** some evidence

that the second admission was also an emergency. . . . " Brown agrees with the trial court.

4. On page 9, Blue Cross completely misstates the Eleventh Circuit's application of *Firestone*. The petition states that the Eleventh Circuit's opinion " . . . imposes essentially *de novo* review with little or no deference to the decision of a plan fiduciary or administrator . . . if the fiduciary or administrator is operating under a potential conflict of interest." That statement attempts to combine the *de novo* review with the arbitrary and capricious standard. *Firestone* clearly states that conflict of interest can be used as one factor to be considered in determining whether Blue Cross was arbitrary and capricious. Petitioners infer it is the *only* factor. The *de novo* standard was not imposed by the Eleventh Circuit in the instant case because Blue Cross was given the very broad discretion with *Firestone* requires.

REASONS FOR DENYING THE WRIT

I. The Eleventh Circuit's Decision Follows This Court's Decision in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989).

The Eleventh Circuit's opinion in the present case follows *Firestone*. Justice O'Connor, in *Firestone*, outlined the principles which would govern facts comparable to those in the case at bar including the conflict of interest which is present here. (At P. 956). In *Firestone*, the *de novo* review was applicable because the trustee had no discretion. In the case at bar, the "trustee" was given broad discretion and the Eleventh Circuit therefore rejected the

de novo review. However, the Eleventh Circuit condoned consideration of the conflict of interest as a factor to be considered. *Firestone* specifically authorized consideration of that factor, saying:

> "Of course, if the benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'factor[ ] in determining whether there is an abuse of discretion.' " (*Firestone*, at 956.)

Petitioners credit the Eleventh Circuit with imposing a *de novo* review without any citation to such a holding. A *de novo* trial is a new trial. As such, it does not inherently demand deference. The Eleventh Circuit specifically rejected a trial *de novo* (at p. 2421) and instructed the trial court to apply whatever deference is consistent with the built-in conflict of interest.

On pages 13-14 of its brief, Blue Cross asserts that the Eleventh Circuit has adopted a **NEW** standard of "no deference" when the trustee has a conflict of interest. This is incorrect. There is nothing new about a "no deference" standard if the conflict of interest is substantial. In *Van Boxel v. Journal Company Employees' Pension Trust*, 836 F.2d 1048 (7th Cir. 1987) the Court said that if there is a "serious conflict of interest, the proper deference to give their decisions may be slight, even zero" (at p. 1052). The Eleventh Circuit cited many cases which undertook to vary the deference consistent with the degree of conflict. *See, e.g., Sage v. Automation, Inc. Pension Plan & Trust*, 845 F.2d 885, 895 (10th Cir. 1988); *Holland v. Burlington Indus., Inc.*, 772 F.2d 1140, 1149 (4th Cir. 1985) sum aff'd. 447 U.S. 901, 106 S.Ct. 3267, 91 L.Ed.2d 559 (1986); *Gilbert v.*

Burlington Indus., Inc., 765 F.2d 320, 328-29 (2nd Cir. 1985) sum aff'd., 447 U.S. 901, 106 S.Ct. 3267, 91 L.Ed.2d 559 (1986); *Jung v. FMC Corp.*, 755 F.2d 708, 711-12 (9th Cir. 1985); *Dennard v. Richards Group, Inc.*, 681 F.2d 306, 314 (5th Cir. 1982); *Maggard v. O'Connell*, 671 F.2d 568, 571 (D.C. Cir. 1982); *see also Gesina v. General Elec. Co.*, 162 Ariz. 39, 780 P.2d 1380, 1383-85 (App.) (adopting variable deference in original opinion decided before *Firestone* and adhering thereto in post-*Firestone* opinion on reconsideration); *rev. denied*, 162 Ariz. 39, 780 P.2d 1380 (1989).

A. The Eleventh Circuit's Standard Affords the Same Deference to the Decisions of Blue Cross as does *Firestone*.

The Eleventh Circuit Standard is taken directly from *Firestone*. The Eleventh Circuit decision affords Blue Cross the exact amount of deference which Justice O'Connor set out. The only standard for the trial court in this case is the arbitrary and capricious standard.

There is no "two-step process" as claimed on page 14 of petitioner's brief. Nowhere does the lower court establish the first step of *de novo* review. On the contrary, the Court specifically instructed the trial court to apply the arbitrary and capricious standard (at p. 2409), but gave instructions to permit proof of a substantial built-in conflict of interest (at p. 2419).

B. The Eleventh Circuit's Standard Makes No Adjustment Whatsoever in the Standard of Review Agreed upon by the Parties in the Plan.

The *de novo* review has no application to the case at bar and the Eleventh Circuit could hardly have made that

point clearer. (At p. 2416). However, since Blue Cross is acting as trustee of its own money and determining what benefits will be paid from Blue Cross's money, the eleventh Circuit opinion simply permits the trial court to consider that substantial conflict of interest in deciding whether Blue Cross was arbitrary and capricious. Furthermore, the Eleventh Circuit was careful to reject the *de novo* review **BECAUSE** such a standard would deny Blue Cross the benefit of its bargain. (At p. 2415).

C. The Eleventh Circuit's Standard Makes No Distinction Between Plans Based upon Method of Funding Unless Specifically Authorized by the *Firestone* Decision.

Firestone specifically approved the Court's consideration of a conflict of interest as one of the factors in determining whether Blue Cross acted arbitrarily and capriciously. (At. p. 956). This is true whether the plan is funded or unfunded. (At p. 956). Such a teaching does not change the arbitrary and capricious standard, but simply gives the trial court a factor which it may consider. Blue Cross does not want the trial court to consider such a conflict of interest. Instead, Blue Cross chooses to label such considerations as "impermissible." (Brief, p. 16)

II. The Eleventh Circuit's Standards are Directly in Keeping with the Applicable Established Principles of Trust Law.

The "normal" definition of a trustee is one who looks after somebody else's money or property. (See *Ballentine's*

Law Dictionary, 3rd Ed., p. 1303). Established trust principles under those conditions dictate that the settlor can avoid litigation by permitting the trustee to determine benefits with finality. However, such a finality clause does not confer on the trustee *carte blanche* to make any payment that he chooses, be he prompted by whim, caprice, altruism or malice. *Hoffa v. Fitzsimmons*, 673 F.2d 1345 (D.C. Cir. 1982). In the instant case, Blue Cross is a "trustee" *only* because of the ERISA definition of trustee. Blue Cross is not charged with the responsibility of looking out for anybody's money except its own. Blue Cross is a trustee only in the sense that it collects the premiums and insures the plan. Such a trustee's decision should certainly be subjected to scrutiny. *Firestone* merely teaches that the Court should subject Blue Cross's decisions in this case to such scrutiny.

III. Further Review by this Court Would Serve Little or No Useful Purpose.

U.S. Supreme Court Rule 17, 28 U.S.C.A. lists the reasons this Court will consider a review on certiorari. The petitioners' *brief* addresses only one of those reasons. Petitioners claim that:

> "Fiduciaries, administrators, and reviewing courts require guidance from this Court with respect to the appropriate standard of review for actions under 29 U.S.C. §1132 where the plan grants a fiduciary discretionary authority to make claims determinations."

However, fiduciaries, administrators, and reviewing courts have already received adequate guidance from

Firestone. Since the Firestone decision, courts have consistently applied the *Firestone* holding. *Newell v. Prudential Insurance Co. of America*, 904 F.2d 644 (11th Cir. 1990); *DeNobel v. Vitro Corp.*, 885 F.2d 1180 (4th Cir. 1989); *Gonzales v. Prudential Insurance Co. of American*, 901 F.2d 446 (5th Cir. 1990); *Bali v. Blue Cross-Blue Shield Assoc.*, 873 F.2d 1043 (7th Cir. 1989); *Anderson v. Blue Cross-Blue Shield of Ala.*, 907 F.2d 1072 (11th Cir. 1990); *Gouras v. Burroughs Wellcome Co.*, ___ F.2d ___ (4th Cir. 1990) No. 90-553; *Alday v. Container Corp. of America*, 906 F.2d 660 (11th Cir. 1990); *Baker v. Big Star Division of the Grand Union Company*, 893 F.2d 288 (11th Cir. 1990); *Deere & Co. v. Kennedy*, 548 N.E.2d 610 (111 App. Div. 1989) *cert. den.* 90-381 ___ U.S. ___; *Exbom v. Central States Southeast and Southwest Areas Health & Welfare Fund*, 900 F.2d 1138 (7th Cir. 1990); *Sokolowski v. Allied-Signal, Inc.*, 735 F.Supp. 163 (E.D. Pa. 1990); *Fair v. International Flavors & Fragrances, Inc.*, 905 F.2d 1114 (7th Cir. 1990); *Guy v. Southeastern Iron Workers' Welfare Fund*, 877 F.2d 37 (11th Cir. 1989); *Retirement Fund Trust of Plumbing v. Franchise Tax*, 909 F.2d 1266 (9th Cir. 1990); *Belade v. ITT Corp.*, 909 F.2d 736 (2nd Cir. 1990); *Memorial Hospital System v. Northbrook Life Ins. Co.*, 904 F.2d 236 (5th Cir. 1990); *Cathey v. Dow Chemical Company Medical Care Program*, 907 F.2d 554 (5th Cir. 1990); *Johnson v. Enron Corp.*, 906 F.2d 1234 (8th Cir. 1990); *Provident Life & Accident Ins. Co. v. Waller*, 906 F.2d 985 (4th Cir. 1990); *Heidgerd v. Olin Corp.*, 906 F.2d 903 (2nd Cir. 1990); *Jader v. Principal Mutual Life Insurance Co.*, 723 F.Supp. 1338 (D.Minn. 1989); *Jett v. Blue Cross & Blue Shield of Ala.*, 890 F.2d 1137 (11th Cir. 1989); *Lakey v. Remington Arms Co., Inc.*, 874 F.2d 1541 (8th Cir. 1989); *Mine Workers, UMW v. Nobel*, 902 F.2d 1558 (3rd Cir. 1990); *PPG Industries Pension*

Plan A(C10) v. Crews, 902 F.2d 1148 (4th Cir. 1990); *Kunstenaar v. Connecticut General Life Insurance Co.*, 902 F.2d 181 (2nd Cir. 1990); *Rucco v. Bateman, Eichler, Hill, Richards, Inc.*, 903 F.2d 1232 (9th Cir. 1990); *Lea v. Republic Airlines*, 903 F.2d 624 (9th Cir. 1990); *Moon v. American Home Assurance*, 888 F.2d 86 (11th Cir. 1989).

The cases cited above, all of which are post-*Firestone*, indicate that there is no confusion and that the circuits are ably carrying out the standards set forth in *Firestone*.

Blue Cross seeks to convince this Court that there is confusion among the circuits. However, the only cases cited for that idea are *Lakey v. Remington, supra, DeNobel v. Vitro Corp., supra,* and *Exbom v. Central States Health & Welfare Fund, supra*. Petitioners assert that *Lakey* follows *Firestone*, while the Fourth Circuit in *DeNobel* does not. However, a careful reading of *DeNobel* reveals that Blue Cross simply *under*quoted the case.

Prior to *Firestone, all* ERISA cases were to be reviewed under the arbitrary and capricious standard. *Firestone* admittedly changed that standard if the fiduciary was not given the necessary discretions. In such cases, the *de novo* standard was adopted. When the Fourth Circuit said that the Supreme Court in *Bruch* "has mandated total abandonment of the 'arbitrary and capricious formulation . . . ' " the court was referring to specific circumstances. The *full* quote is that the Supreme Court "has mandated the abandonment of the arbitrary and capricious formulations **THAT GUIDED THE DISTRICT COURT IN THE PRESENT CASE.**" The Fourth Circuit then proceeded to determine whether the trial court *should* have adopted the *de novo* standard in that

case. The Fourth Circuit concluded that the plan's fiduciary *was* given broad discretion and, pursuant to *Firestone*, the trial court had properly applied the arbitrary and capricious standard as mandated by *Firestone*. In short, there is no conflict.

Blue Cross would like this Court to rule that under ERISA, "any" discretion is the same as "all" discretion. Petitioners seek to advance a standard which essentially gives them *carte blanche* to award or deny benefit claims under ERISA with no accountability for their motives and/or the consequences to the plan participants. Such a standard would unequivocally conflict with the intent of ERISA and would be exactly the throwback to pre-ERISA days so eloquently condemned by Justice O'Connor in *Firestone*. (At p. 956).

Petitioners contend (at p. 19) that "*Firestone* teaches trust law forms the basis for determining the appropriate standard of review . . . " under ERISA. *Firestone*, however, rejects the notion that trust law forms a basis -- it "guides." (At p. 954).

Finally, petitioners claim that Blue Cross, and others similarly situated, "will face a continued uncertainty as to the finality of their decisions in the administration of these plans, their ability to contractually (sic) provide for discretionary authority and review of an administrator's decision, and the extent to which courts may interpose their judgments in the place of the administrator or fiduciary." (At p. 28-29). Such "uncertainty" is only created when Blue Cross and others similarly situated, create a "substantial conflict of interest" in their programs.

CONCLUSION

For these reasons, the granting of a writ of certiorari would serve no useful purpose and should be denied.

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